COMPETITIVE COMMENTS ON ROWAN COUNTY

2020 HOSPICE HOME CARE OFFICE NEED DETERMINATION

SUBMITTED BY CONTINUUM CARE OF NORTH CAROLINA LLC

Continuum Care of North Carolina LLC (CCNC) proposes to develop a hospice home care office in Rowan County (Project ID No. F-011955-20). Seven additional applications were submitted in response to the need determination in the 2020 State Medical Facilities Plan ("SMFP") for one new hospice home care office in Rowan County:

These comments are submitted by CCNC in accordance with N.C. Gen. Stat. § 131E-185(a1)(1) to address the representations in the applications, including a comparative analysis and a discussion of the most significant issues regarding the applicants' conformity with the statutory and regulatory review criteria ("the Criteria") in N.C. Gen. Stat. §131E-183(a) and (b). Other non-conformities in the competing applications may exist. Nothing in these Comments is intended to amend the CCNC Application and nothing contained here should be considered an amendment to the CCNC Application as submitted.

COMPARATIVE COMMENTS

The Healthcare Planning and Certificate of Need Section developed a list of suggested comparative factors for competitive batch reviews. The following factors are suggested for all reviews regardless of type of services or equipment proposed:

- Conformity with Statutory and Regulatory Review Criteria
- Scope of Services
- Historical Utilization
- Geographic Accessibility (Location within the Service Area)
- Access by Service Area
- Access by Underserved Groups: Charity Care
- Access by Underserved Groups: Medicaid
- Access by Underserved Groups: Medicare
- Competition (Access to a New or Alternate Provider)
- Projected Average Net Revenue per Patient, Procedure, Case or Visit
- Projected Average Total Operating Cost per Patient, Procedure, Case or Visit

Project Analysts have discretion to apply additional factors based on the type of proposal. The following table summarizes the competing applications relative to the suggested comparative factors and additional factors relevant to hospice reviews, ranking the proposals as more effective, equally effective, and less effective.

Comparative Factor	Continuum Care of North Carolina LLC	Adoration Home Health & Hospice, Inc.	Amedisys Hospice, LLC	BAYADA Home Health Care, Inc.	Carolina Caring	Hospice of Iredell County, Inc.	Personal Home Care of North Carolina, LLC	PruittHealth Hospice, Inc.
Conformity with Review Criteria	Most Effective	Least Effective	Least Effective	Least Effective	Least Effective	Least Effective	Least Effective	Least Effective
Scope of Services	Most Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective
Historical Utilization	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Geographic Accessibility	Equally Effective	Equally Effective	Equally Effective	Equally Effective	Equally Effective	Equally Effective	Equally Effective	Equally Effective
Access by Service Area Residents	More Effective	Less Effective	Less Effective	Less Effective	More Effective*	Most Effective*	Less Effective	Less Effective
Competition (Access to a New or Alternate Provider)	Most Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective
Access by Underserved Groups: Charity Care	Most Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective
Access by Underserved Groups: Medicaid	Most Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective
Access by Underserved Groups: Medicare	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Most Effective*
Projected Average Net Revenue per Patient Day	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Projected Average Net Revenue per Admission	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Projected Average Operating Expense per Patient Day	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Projected Average Operating Expense per Admission	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Average Case Load for Key Hospice Staff								
Registered Nurse	More Effective	Less Effective	Less Effective	More Effective*	Less Effective	Less Effective	Most Effective*	Less Effective
Social Worker	More Effective	Less Effective	Less Effective	More Effective*	Less Effective	Less Effective	Most Effective*	Less Effective
Hospice Aide	Most Effective	Less Effective	Less Effective	Most Effective*	Less Effective	Less Effective	Less Effective	Less Effective
Chaplain	Most Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective	Less Effective

*Applicant does not conform with Review Criteria, thus cannot be approved.

Conformity to CON Review Criteria

Seven CON applications have been submitted seeking one hospice home care office in Rowan County. Based on the 2020 SMFP's need determination for one additional hospice home care office, only one application can be approved. Only applicants demonstrating conformity with all applicable Criteria can be approved, and only the application submitted by CCNC demonstrates conformity to all Criteria:

Conformity of Proposed Facilities

Applicant	Project I.D.	Conforming/ Non-Conforming
BAYADA Home Health Care Inc.	F-011943-20	No
Amedisys Hospice, LLC	F-011945-20	No
Hospice of Iredell County, Inc.	F-011948-20	No
Adoration Home Health & Hospice	F-011949-20	No
PruittHealth Hospice, Inc.	F-011952-20	No
Continuum Care of North Carolina	**F-011955-20**	**Yes**
Carolina Caring	F-011956-20	No
Personal Home Care of North Carolina, LLC	F-011957-20	No

The CCNC application for a hospice home care office is based on reasonable and supported volume projections and adequate projections of cost and revenues. As discussed below, the competing applications contain errors and flaws which result in one or more non-conformities with statutory and regulatory review Criteria. Therefore, CCNC is the most effective alternative regarding conformity with the review criteria.

Scope of Services

While each of the competing applicants propose to develop new hospice home care offices that will provide core services, CCNC will provide a service intensity that sets it above and beyond conventional hospice programs. Through its level of service intensity and all its unique programs, there are several characteristics of the proposed CCNC hospice program that distinguish it from the other hospice programs proposed by competing applicants. Most significantly, CCNC prides itself on its service intensity, which surpasses national averages. All efforts will be made to ensure that every new patient will be seen at CCNC within two hours of referral, seven days a week. The two-hour turnaround goal is a testament to CCNC's dedication to serving the needs of hospice appropriate patients.

Second, CCNC prides itself on the ability to provide home health aide visits at a service intensity of between 5 to 7 visits per week based upon the patient's plan of care, which allows CCNC to recognize changes in the patient ahead of the curve and be proactive rather than reactive. This helps to provide more comfortable outcomes for the patient and dually prevent unnecessary hospitalizations.

A third service intensity feature is that CCNC staffs for a nurse visit twice weekly based upon the patient's plan of care, and more frequently if the patient is actively passing to provide symptom management and proper planning.

A fourth service intensity feature is that CCNC will provide a social worker and clergy member (based on patient or family preferences) at least weekly, which helps to keep families and loved ones well supported.

Documentation of CCNC's proposed service intensity is included in Form F.4 Revenue. Specifically, CCNC includes service intensity add-on (SIA) payments. CMS provides a SIA payment for routine home care visits by a registered nurse or social worker to meet the increased clinical and emotional needs of patients in the last 7 days of life and their families. SIA payments are reflective of a high-quality, service-intense hospice provider. Many of the competing applicants do not account for SIA payments which casts doubt on any potential claim of superiority regarding respective scope of services or intensity.

CCNC will also offer unique service programs including music therapy, virtual reality therapy, equine facilitated support, veterans programming, and minority outreach. These programs are described in detail throughout CCNC's application.

Applicant	Routine	Inpatient	Respite	Veterans Programming	Music Therapy	Virtual Therapy	Equine Therapy
Continuum Care of North Carolina	X	X	X	X	X	X	X
Adoration Home Health & Hospice	X	X	X	X			
Amedisys Hospice	X	X	X	X			
BAYADA Home Health Care	X	X	X	X			
Carolina Caring	X	X	X	X			
Hospice of Iredell County	X	X	X	X			
Personal Home Care of North Carolina	X	X	X	X			
PruittHealth Hospice	X	X	X	X			

Historical Utilization

Three applicants provided hospice services in Rowan County during FFY2019 (either directly for via affiliate entity). The following table illustrates historical utilization of the respective providers as provided in the Proposed 2021 SMFP representing FY2019 reported utilization.

Hospice Offices Serving Rowan County Hospice Patients
Proposed 2021 SMFP Based on FY2019 Data

Provider	Admissions	Days of Care	Deaths
PruittHealth Hospice (HOS4413)	25	1,819	31
Carolina Caring (HOS0367)	27	1,700	16
Hospice of Iredell County (HOS0387)	3	230	2

Source: 2021 Proposed SMFP Chapter 13: Hospice Data by County of Patient Origin – 2019 Data (updated as of 6-12-2020)

Five of the applicants do not have a history of providing hospice services to Rowan County patients. Thus, the result of this comparative is inconclusive.

Geographic Accessibility

Each of the applicants propose to develop a new hospice home care office in Rowan County. Hospice care is predominately provided in the patient's place of residence. Thus, all applicants are effective alternatives with respect to geographic accessibility.

Although facilities may serve residents outside of their proposed service area, patient origin projections must be reasonable and adequately supported. The applicants in this review present markedly different patient origin projections. Applicants such as Pruitt project to admit a significant number of patients residing not only outside of Rowan County, but in Counties that are a considerable distance from Rowan County, i.e., the County with the identified need determination. These applicants are less effective alternatives on this factor for meeting the needs of Rowan County residents.

Hospice of Iredell County projects service to only one County and provides no assumptions to support its decision not to serve neighboring Stanly County, a County with a projected hospice deficit. Hospice of Iredell County is a less effective alternative on this factor.

As it did in the 2017 Mecklenburg County Home Health Review, it is appropriate for the Analyst to compare the hospice deficits in the 2020 SMFP with the Counties proposed to be served by each Applicant. Applicants who propose to serve Rowan and Stanly Counties will provide service to Counties with a reported deficit. Other applicants proposing to serve Counties with no reported deficits are less effective alternatives in terms of enhancing access to service in geographic areas with a reported hospice deficit.

Access By Service Area Residents

On page 305, the 2020 SMFP states, "Each of the 100 counties in the state is a separate hospice office service area." Therefore, for the purpose of this review, Rowan County is the service area. Facilities may also serve residents of counties not included in their service area.

The following table illustrates access by service area residents during the third full fiscal year following project completion.

	Continuum Care of NC	Adoration	Amedisys	BAYADA	Carolina Caring	Hospice of Iredell County	Personal Home Care	PruittHealth Hospice
Rowan County Admissions Served as a % of Total Admissions	96%	57%	82%	87%	96%	100%	84%	55%

As shown in the table above, HOIC projects to serve the highest percentage of service area residents. CCNC and Carolina Caring project to serve the next highest percentage of service area residents. However, neither HOIC nor Carolina Caring comply with all applicable statutory and regulatory criteria and therefore neither HOIC nor Carolina Caring are approvable. Therefore, regarding projected service to percentage of service area admissions as compared to total admissions served, CCNC is the most effective alternative.

Competition (Access to a New or Alternate Provider)

CCNC will be a new entrant in the North Carolina and Rowan County hospice market and is the most effective alternative for improving competition in this batch review.

As described previously, PruittHealth Hospice, Carolina Caring, and Hospice of Iredell County currently serve Rowan County hospice patients. Therefore, PruittHealth Hospice, Carolina Caring, and Hospice of Iredell County are the least effective alternatives with respect to this comparative.

Adoration's parent company owns Advanced Home Care (HC0399) which operates a home health agency in Rowan County. Therefore, the Adoration application is a less effective alternative in terms of improving competition.

Amedisys operates hospice agencies in Alamance, Brunswick, Franklin, Pitt, Robeson, Wake, and Washington counties. Therefore, the Amedisys application is a less effective alternative in terms of improving competition.

Bayada operates a hospice agency in Cumberland County. Therefore, the Bayada application is a less effective alternative in terms of improving competition.

Access By Underserved Groups

Underserved groups are defined in G.S. 131E-183(a)(13) as follows:

"Medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority."

For access by underserved groups, applications are compared with respect to three underserved groups: charity care patients (i.e., medically indigent or low-income persons), Medicare patients, and Medicaid patients. Access by each group is treated as a separate factor.

The Agency may use one or more of the following metrics to compare the applications:

- Total charity care, Medicare or Medicaid admissions
- Charity care, Medicare or Medicaid admissions as a percentage of total admissions
- Total charity care, Medicare or Medicaid dollars
- Charity care, Medicare or Medicaid dollars as a percentage of total gross or net revenues

Which of the above metrics the Agency uses is determined by whether or not the applications included in the review provide data that can be compared as presented above and whether or not such a comparison would be of value in evaluating the alternative factors.

Projected Charity Care

The following table compares projected charity care in the third full fiscal year following project completion for all the applicants as a percentage of gross revenue, and per admission.

	Continuum Care of NC	Adoration	Amedisys	BAYADA	Carolina Caring	Hospice of Iredell County	Personal Home Care	PruittHealth Hospice
Charity Care Admissions	5	7	3	3	3	3	1	5
Charity Care Admissions as a % of Total Admissions	2.6%	2.7%	1.1%	1.2%	1.3%	1.3%	0.4%	1.6%
Charity Care Deduction From Revenue	$91,575	$89,772	$6,649	$45,699	$58,539	$69,791	$43,060	$68,871
Total Gross Revenue	$3,430,637	$3,297,918	$3,372,808	$4,157,844	$3,562,109	$3,768,435	$4,377,033	$4,588,273
Charity Care Deduction as a % of Total Gross Revenue	2.7%	2.7%	0.2%	1.1%	1.6%	1.9%	1.0%	1.5%

As a percent of total admissions, CCNC and Adoration are the most effective alternatives. However, Adoration does not comply with all applicable statutory and regulatory criteria and therefore Adoration is not approvable. CCNC provides a higher dollar amount of charity care deduction from gross revenue than any of the other applicants. CCNC also provides the highest charity care deduction as a percent of gross revenue than any of the other applicants. Therefore, CCNC is the most effective alternative with respect to access for charity care hospice patients.

Projected Medicare

The following table compares projected access by Medicare patients in the third full fiscal year following project completion for all the applicants in the review.

	Continuum Care of NC	Adoration	Amedisys	BAYADA	Carolina Caring	Hospice of Iredell County	Personal Home Care	PruittHealth Hospice
Medicare Admissions	171	245	249	217	202	224	203	296
Medicare Admissions as a % of Total Admissions	88.0%	93.2%	91.2%	90.0%	90.2%	94.1%	89.4%	96.1%
Medicare Gross Revenue	$2,923,337	$3,153,943	$3,138,833	$3,742,394	$3,159,681	$3,327,498	$3,805,286	$4,405,148
Medicare Gross Revenue as a Percentage of Total Gross Revenue	85.2%	95.6%	93.1%	90.0%	88.7%	88.3%	86.9%	96.0%

PruittHealth proposes the highest Medicare admissions, highest Medicare admissions as a percent of total admissions, highest Medicare gross revenue, and highest percentage of Medicare as a percent of gross revenue. However, neither PruittHealth nor the other competing applications comply with all applicable statutory and regulatory criteria and therefore neither Pruitt Health nor the other competing applications are approvable. Therefore, regarding access by Medicare patients, CCNC is the most effective alternative.

Projected Medicaid

The following table compares projected access by Medicaid patients in the third full fiscal year following project completion for all the applicants in the review.

	Continuum Care of NC	Adoration	Amedisys	BAYADA	Carolina Caring	Hospice of Iredell County	Personal Home Care	PruittHealth Hospice
Medicaid Admissions	14	5	14	15	11	2	11	3
Medicaid Admissions as a % of Total Admissions	7.0%	1.9%	5.1%	6.2%	4.9%	0.8%	4.8%	1.0%
Medicaid Gross Revenue	$240,102	$67,753	$149,795	$255,501	$171,329	$66,984	$241,984	$41,210
Medicaid Gross Revenue as a Percentage of Total Gross Revenue	7.0%	2.1%	4.4%	6.1%	4.8%	1.8%	5.5%	0.9%

Bayada projects the highest number of Medicaid admissions and highest Medicaid gross revenue. However, Bayada does not conform with all applicable statutory and regulatory criteria and, therefore, Bayada cannot be approved. CCNC projects the second highest number of Medicaid admissions and second highest Medicaid gross revenue. CCNC projects the highest Medicaid gross revenue as a percent of total gross revenue. Therefore, CCNC is the most effective alternative with respect to access for Medicaid hospice patients.

Projected Average Net Revenue

The following table compares the projected average net revenue per patient day and projected average net revenue per patient for the third year of operation following project completion for all the applicants, based on the information provided in the applicants' pro forma financial statements (Section Q).

	Continuum Care of NC	Adoration	Amedisys	BAYADA	Carolina Caring	Hospice of Iredell County	Personal Home Care	PruittHealth Hospice
Net Revenue	$2,894,193	$2,877,865	$3,290,787	$3,509,328	$3,408,166	$3,550,360	$4,021,394	$4,416,470
Net Revenue Per Patient Day	$192	$175	$162	$186	$212	$191	$218	$191
Net Revenue Per Unduplicated Admission	$14,919	$10,942	$12,054	$14,562	$15,215	$14,917	$17,715	$14,339

Regarding this factor, historically the Agency has considered the application proposing the lowest average net revenue as the more effective alternative citing the rationale that "a lower average may indicate a lower cost to the patient or third-party payor."[1] However, this is not the case with hospice care because it is predominately reimbursed by Medicare and Medicaid. As described previously, the applicants in this Rowan County hospice batch review project Medicare and Medicaid reimbursement will account for approximately 92% - 97% of total projected gross revenue. Medicare and Medicaid have set payments for hospice reimbursement; therefore, the payors for the proposed services will not incur higher costs for the services proposed. In fact, with respect to provision of hospice services as proposed by CCNC, higher revenue is indicative of high-quality, service-intense hospice care. CMS introduced the Intensity Add-On (SIA) program in 2016 to allow hospices to bill an additional payment on an hourly basis for registered nurse and social worker visits during the last seven days of a patient's life in addition to their standard per diem reimbursement. The number of registered nurse and social worker visits during a patient's final week is one of the seven quality measures that CMS uses to evaluate providers for its Hospice Compare website, which allows consumers, payors, and referring organizations to benchmark performance of individual providers against one another.

As shown in Form F.4 Revenues, CCNC's projected net revenue includes SIA payments which are separately itemized from its Medicare revenue by level of care. Therefore, CCNC's projected average net revenue per patient day and per patient is reflective of its commitment to provision of high quality, service-intense hospice services. Many of the competing applicants did not identify SIA payments; thus, it is not clear whether their respective revenues are reflective of service intensity or SIA payments. Therefore, because 1) the payors for the proposed hospice services will not incur higher costs for the services proposed and 2) the uncertainty surrounding other competing applicants commitment to service intensity and receipt of SIA payments, one cannot make a conclusive determination regarding the most effective alternative for this comparison.

[1] Agency Findings for 2019 Wake County MRI Review

Projected Average Total Operating Cost

The following table compares the projected average operating expense per patient day and per admission for the third year of operation following project completion for all the applicants, based on the information provided in the applicants' pro forma financial statements (Section Q).

	Continuum Care of NC	Adoration	Amedisys	BAYADA	Carolina Caring	Hospice of Iredell County	Personal Home Care	PruittHealth Hospice
Operating Costs	$2,645,094	$2,116,099	$2,891,962	$2,809,350	$2,526,015	$3,242,435	$3,705,979	$3,464,548
Cost Per Patient Day	$175	$128	$142	$149	$157	$175	$201	$150
Cost Per Unduplicated Admission	$13,635	$8,046	$10,593	$11,657	$11,277	$13,624	$16,326	$11,249

Regarding this factor, historically the Agency has considered the application proposing the lowest average operating expense as the more effective alternative citing the rationale that "a lower average cost may indicate a lower cost to the patient or third-party payor or a more cost-effective service."[2] As described previously, the applicants in this batch review project Medicare and Medicaid reimbursement will account for approximately 92% - 97% of total projected gross revenue. Medicare and Medicaid have set payments for hospice reimbursement; therefore, the payors for the proposed services will not incur higher costs for the services proposed. In fact, with respect to provision of hospice services as proposed by CCNC, higher costs are indicative of high-quality, service-intense hospice care. Over two-thirds of CCNC's operating costs are attributable to staff salaries and benefits during the third project year. As described separately in this comparative analysis, CCNC projects the lowest overall average caseload for key clinical hospice staff. A lower ratio of patients to clinical staff increases a hospice provider's ability to meet the needs of patients and families through appropriate use of resources and achieving the quality goals set by the hospice program. CCNC's respective costs are necessary to support the staffing levels needed to projected average caseload for key clinical staff who will provide service-intense hospice care to CCNC's projected patients. Competitive salaries are also useful in recruiting qualified staff. Thus, CCNC's projected average operating cost per patient day and per patient is reflective of its commitment to provision of high quality, service-intense hospice services. Other competing applicants have significantly higher average caseloads compared to CCNC, which may contribute to respectively lower average operating costs. However, the respective applicants would have similarly fewer resources to meet the needs of patients and families, which is a less effective alternative with respect to provision of high-quality care. Also, several of the applicants failed to include necessary expenses for workers compensation insurance, room and board, and respite care; therefore, many of the applicants' average costs are unreliable.

It would be inappropriate for the Agency to incentivize applicants to artificially minimize operating costs in an anticipated competitive hospice batch review based on the improper assumption that "a lower average cost may indicate a lower cost to the patient or third-party payor or a more cost-effective service." Similarly, it will be inappropriate for the Agency to apply this rationale in this Rowan County

[2] Agency Findings for 2019 Wake County MRI Review

hospice batch review. Therefore, because 1) the payors for the proposed hospice services will not incur higher costs for the services proposed; and 2) there is a correlation between average caseload and available resources for provision of quality care, one cannot make a conclusive determination regarding the most effective alternative using this comparison.

Average Caseload for Key Hospice Staff

In the hospice application form, Section H.2 requires the applicant to provide average caseload for key hospice staff and states: "*Average caseload means the preferred number of patients for which a staff member has responsibility or to which she or he is assigned at any one time. This should not be expressed as a range but instead as a single number*."

The table in H.2 includes Registered Nurse, Social Worker, Hospice Aide, Chaplain, and Volunteer. CCNC notes volunteers are not paid hospice staff. CCNC completed the table in Section H.2 to reflect the average caseload for the volunteer coordinator which is a staff position. It is unclear whether the other competing applicants provide average caseloads for volunteer coordinator staff position or unpaid volunteer. Therefore, CCNC omitted this position from the following analysis.

The following table summarizes the projected average caseload for all the applicants, based on the information in provided in response to Section H.2.

	Continuum Care of NC	Adoration	Amedisys	BAYADA	Carolina Caring	Hospice of Iredell County	Personal Home Care	PruittHealth Hospice
Registered Nurse	10	12	13	10	12	12.5	9	12
Social Worker	25	31	45	25	35	29	24	30
Hospice Aide	8	13	11	8	10	9.5	10	10
Chaplain	25	51	55	35	50	57.5	35	40

CCNC and Personal Home Care project the lowest average caseload for key clinical hospice staff. However, Personal Home Care does not conform to all applicable statutory and regulatory criteria and therefore Personal Home Care is not approvable. Therefore, CCNC is the most effective alternative of the competing applicants.

CCNC's projected average caseload per hospice staff position and corresponding staffing projections are consistent with NHPCO staffing guidelines. A lower ratio of patients to clinical staff increases a hospice provider's ability to meet the needs of patients and families through appropriate use of resources and achieving the quality goals set by the hospice program. High caseloads can contribute to a long work week and high number of hours worked resulting in high levels of stress. Also, increased workload and caseload can prevent hospice staff from getting adequate rest and from providing the necessary care and attention to clients and their families. Thus, from a qualitative perspective, it is relevant and useful for the Agency to consider this comparative and apply it to the Rowan County hospice batch review.

For the foregoing reasons, CCNC is the most effective alternative with respect to average caseload for hospice staff.

Summary

For each of the comparative factors previously discussed, CCNC's application is determined to be the most effective alternative with the following comparative metrics:

- Conformity with Review Criteria
- Scope of Services
- Access by Service Area
- Competition (Access to a New or Alternate Provider)
- Access by Underserved Groups: Charity Care
- Access by Underserved Groups: Medicaid
- Access by Underserved Groups: Medicare
- Average Case Load for Key Hospice Staff

COMMENTS SPECIFIC TO BAYADA HOME HEALTH CARE INC. (Bayada)
PROJECT ID No. F-011943-20

Criterion 1 *"The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which shall constitute a determinative limitation on the provision of any health services, health service facility, health service beds, dialysis stations, operating rooms, or home health offices that may be approved."*

POLICY GEN-3: BASIC PRINCIPLES states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

Bayada fails to conform with Criterion 1 and Policy GEN-3 because the application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. The applicant does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. See discussion regarding criteria 3, 4, 5, 6, 7, 8, 13c, and 18a. Therefore, the application is not conforming to this criterion and cannot be approved.

Criterion 3 *"The applicant shall identify the population to be served by the proposed project and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed."*

<u>Need Methodology</u>

Bayada's Need Methodology calculates the TOTAL projected deaths served by hospice for Rowan and Stanly Counties and then projects to capture stated market share of those deaths. Using Bayada's approach, its market share percentages for each of the first three years of operation are represented as 12%, 18% and 24%, respectively for Rowan County, and 4%, 6%, and 8%, respectively for Stanly County.

CCNC's Need Methodology calculates the DEFICITS in projected deaths served by hospice for Rowan and Stanly Counties and then projects to capture stated market share of those deaths. Using CCNC's approach, its market share percentages for each of the first three years of operation are 75%, 85% and 95%, respectively for Rowan County, and 10%, 15%, and 20%, respectively for Stanly County.

The two methodologies are different and, to be clear, the Applicants' "market share" percentages are not appropriate for an apples-to-apples comparison, as explained below.

Using the assumptions from the SMFP (as used by CCNC at p. 108 of its Application), the hospice death DEFICITS in Rowan and Stanly County are:

Unserved Hospice Deaths	PY 1	PY 2	PY 3
Rowan	163	167	170
Stanly	34	35	35

Bayada projects to serve:

Bayada Projected Hospice Deaths to be Served	PY 1	PY 2	PY 3
Rowan	91	138	187
Stanly	14	21	28

CCNC projects to serve:

CCNC Projected Hospice Deaths to be Served	PY 1	PY 2	PY 3
Rowan	122	142	162
Stanly	3	5	7

Based on the above, the following compares the market share percentages of unserved hospice deaths during the first three years of its proposed project:

Bayada Projected % of Service of Unserved Hospice Deaths	PY 1	PY 2	PY 3
Rowan	55.8%	82.6%	110.0%
Stanly	41.2%	60.0%	80.0%

CCNC Projected % of Service of Unserved Hospice Deaths	PY 1	PY 2	PY 3
Rowan	75.0%	85.0%	95.0%
Stanly	10.0%	15.0%	20.0%

As can be seen via the previous tables, CCNC projects to serve a higher percentage of unserved hospice deaths from Rowan County as compared to Bayada in the first project year. Both applicants project comparable percentages from Rowan County in the second project year. However, Bayada's market share projections in all other instances across both Counties are significantly more aggressive when compared to the projections of CCNC.

Bayada's PY 3 market share projection is unreasonable and unsupported by information in the Bayada Application as it amounts to a projection that Bayada will serve ALL unserved hospice death ***plus*** another 10% of deaths already served by existing providers. Moreover, Bayada's projections for Stanly County are not reasonable and supported by information in the Bayada Application, especially considering that to meet its projections, Bayada would have to serve fully 80% of the unserved hospice deaths from Stanly County by PY 3.

While at first blush, the Bayada market share percentages appear to be smaller numbers, an appropriate analysis shows the Bayada projections are not reasonable and adequately supported, especially the Bayada projections for Stanly County and PY 3.

Criterion 4 "*Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed."*

Bayada is nonconforming with the following statutory review criteria: Criteria 1, 3, 5, 6, 7, 8, 13c, and 18a. See these criteria for discussion. Therefore, Bayada failed to adequately demonstrate that its proposal is an effective alternative for development of a hospice home care office in Rowan County. Consequently, the application is nonconforming to this criterion.

Criterion 5 *"Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service."*

Understated Capital Cost

Bayada fails to identify any Consultant Fee on its Form F.1.a Capital Cost form. As a result, Bayada does not document availability of funds in an amount sufficient to account for the full extent of Capital Costs associated with its proposed project. No other assumption identified in the Bayada Application accounts for the Consultant Fee.

Also, Bayada projects a generic $25,000 for each expected line item. Bayada refers to the capital costs as "allowances"; therefore, the Applicant failed to apply any specific assumptions or rationale to project the anticipated capital costs.

Form F.3 Errors

As shown on Form F.3 (page 109) Bayada assumes no reimbursement rate for Self-Pay.

Bayada assumes no annual increase in reimbursement rates. This is likely a strategy to artificially suppress revenues in anticipation of a comparative analysis.

Form F.4 Errors

Bayada assumes no reimbursement rate for Self-Pay; however, Form F. 4 includes Self-Pay revenue during each project year.

Bayada failed to account for the time during its Medicare/Medicaid certification period in which it will not receive revenues from the respective payors. Based on CCNC's leadership experience developing new hospice offices, the certification period is approximately two months. Failure to account for two months of forgone revenue results in grossly overstated revenues during the first project year. As a result, Bayada's projected initial operating expenses are grossly understated, which results in failure to adequately demonstrate available capital for the project.

Form F.5 Errors

The Bayada application failed to account for applicable Room & Board expenses in Form F.5 Operating Costs. A Medicare-certified/NC Licensed hospice agency is able to provide hospice services in a nursing home facility where the recipient can be dually eligible for Medicaid where Medicaid covers the cost of the patients nursing home room and board less any patient share of cost. In North Carolina, the hospice agency must bill NC Medicaid for the room & board charges and in turn the hospice receives reimbursement at 95% and less any patient share of cost and Medicare pays the hospice for the hospice benefit. A hospice provider must have a contract with a nursing home if services are provided within those facilities which will include the guidance on how the nursing home room and board is handled including compensation.

In November 1997, the Office of the Inspector General reported on Hospice and Nursing Home Contractual Relationships and identified in their findings that "*Almost all hospices reviewed pay nursing homes the same or more than what Medicaid would have paid for nursing home care if the patient had not elected hospice.* " https://oig.hhs.gov/oei/reports/oei-05-95-00251.pdf With that being said, **there would be an expense created for the hospice of at least 5% which should be reported in the financials as a cost**. The basis for this cost would be the percentage of patients the hospices serve in nursing homes. NHPCO-Facts-Figures-2020-edition reported that at least 17.27% of patient's location of care is in a nursing facility. Similarly, based on the 2020 Hospice Data Supplements for the hospice offices located in Rowan County, approximately 19.9% of patients' care was provided in a nursing facility during FFY2019. Please see the following table.

Location of Care	Trellis Supportive Care (HOS2425)	Novant Health Hospice (HOS4599)	Combined Total	% of Total
Home	169	182	351	73.2%
Nursing Facility	74	53	127	19.9%
Hospice Unit		-	-	0.0%
Hospital		-	-	0.4%
Hospice IP Facility		-		-
Residential	34	17	51	6.6%
Total	277	252	529	100.0%

Source: 2020 Hospice Data Supplements, Section D, page 4

Therefore, based on the historical experience of hospice offices located in Rowan County, one can reasonably project that a comparable percentage of patients will be served in a nursing facility. However, Bayada failed to identify any costs for Room & Board expense in Form F.5 Operating Costs.

For the aforementioned reasons, all applicants providing hospice services should include charges and expenses related to Nursing Home Room & Board passthrough. In reporting this expenditure for the CON, CCNC identified this expenditure as Room & Board Expense on Form F.5. Operating Costs. In addition, CCNC identified inpatient costs for respite and GIP stays at contracted facilities on the same form. Of the seven applicants in the Rowan Count hospice batch review, only two applicants (CCNC and Amedisys) identified that there was an expense related to servicing patients in a facility.

Consequently, Bayada does not conform to Criterion 5 because it failed to account for Room and Board expenses associated with providing hospice care in a nursing home.

Criterion 6 *"The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities."*

Bayada failed to adequately demonstrate the need for the proposed services (See Criterion 3). Therefore, Bayada failed to adequately demonstrate that its proposal will not result in an unnecessary duplication of existing or approved home health services and is nonconforming to this criterion.

Criterion 7 "*The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided."*

Bayada's staffing is insufficient to provide staffing per its Average Caseload. Section H.2 requires the applicant to provide the average caseload by hospice discipline. In the hospice CON application, average caseload means the number of patients for which a staff member has responsibility or to which she or he is assigned at any one time. One can easily calculate the staff needed to support projected average caseload based on the following steps: 1) determine average daily census by dividing annual days of care by 365, 2) divide the average daily census by the average caseload for each staff discipline to determine the quotient, i.e. staff discipline needed.

The following table summarizes the staff required to meet Bayada projected staffing needs for each staff discipline during the first three project years based on the Applicant's projected days of care (Form C) and the average case load per discipline (Section H.2).

		PY1	PY 2	PY 3
Form C Days of Care ÷ 365	Days of Care, PY2 ADC	7,024 19.2	12,472 34.2	18,830 51.6
H.2 ADC ÷ Avg Case Load Form H	RN Avg Case Load Staff Needed Staff Projected *RN Staff Surplus/(Deficit)*	10.0 1.92 2.40 *0.48*	10.0 3.42 4.50 *1.08*	10.0 5.16 6.20 *1.04*
H.2 ADC ÷ Avg Case Load Form H	SW Avg Case Load Staff Needed Staff Projected *SW Staff Surplus/(Deficit)*	25.0 0.77 0.80 *0.03*	25.0 1.37 1.00 *(0.37)*	25.0 2.06 1.10 *(0.96)*
H.2 ADC ÷ Avg Case Load Form H	Aide Avg Case Load Staff Needed Staff Projected *Aide Staff Surplus/(Deficit)*	8.0 2.41 2.40 *0.25*	8.0 4.27 4.50 *0.23*	8.0 6.45 6.20 *(0.25)*
H.2 ADC ÷ Avg Case Load Form H	Chaplain Avg Case Load Staff Needed Staff Projected *Chaplain Staff Surplus/(Deficit)*	35.0 0.55 0.25 *(0.30)*	35.0 0.98 0.40 *(0.58)*	35.0 1.47 0.40 *(1.07)*

As shown in the previous table, Bayada projects insufficient social worker, hospice aide, and chaplain/clergy staff to support its projected average case load. The staffing needs are discipline specific; thus, the Applicant cannot claim the staffing deficits will met by an alternate staff discipline. The staffing deficiencies have multiple consequences to Bayada's application. Specifically,

- Bayada does not conform to Criterion 7 because it does not show evidence of adequate health manpower for the provision of the proposed hospice services.
- Bayada does not conform to Criterion 5 because its operating costs and resulting revenues are not based on adequate hospice staff projections.
- Bayada's Average Case Load projections are not supported; therefore, the comparative analysis of this factor is inconclusive.

Criterion 8 *""The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system."*

In Section I.1 (page 64), Bayada identifies the ancillary and support services required for its proposal, which include:

- Pharmacy Services
- Inpatient Care
- Respite Care

The Applicant refers to Exhibit I.2 for copies of correspondence to the facilities in Rowan and adjoining counties as well as a sample agreement for services. However, Exhibit I.2 does not include a letter from the proposed provider of inpatient care or respite care. Consequently, Bayada failed to adequately demonstrate that inpatient and respite services will be available and coordinated for the proposed project.

The Applicant also failed to identify whether dietary services will be available to the proposed Rowan County hospice office. Per 10A NCAC 13K .0102(6), "Dietary Counseling" means counseling given by a licensed dietitian as defined in G.S. 90-357. Bayada provided no documentation regarding availability of a dietician or how dietary counseling will be provided.

Consequently, the applicant does not adequately demonstrate that it will provide or make arrangements for the necessary ancillary and support services, and that the proposed services will be coordinated with the existing health care system. Therefore, the application is not conforming to this criterion.

Criterion 13c *"The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:*

> *(c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services."*

Bayada failed to provide the assumptions and methodology used to project payor mix for the proposed hospice home care office. Section L.3(b) requires the applicant to "Provide the assumptions and methodology used to project each payor source." However, Bayada's response failed to include the rationale it used to derive projected payor mix for each payor source. CCNC's notes the payor mix differs between new admissions and days of care, but Bayada did not include any information to explain the difference in payor mix. Thus, absence of any rationale results in questionable payor mix projections. Furthermore, the payor mix projections for new hospice admissions in response to Section L.3(b) do not reconcile with the payor mix projections for new hospice admissions in Form C Utilization (page 102). Please see the following table.

Bayada Payor Mix Projections, Hospice Admissions		
Payor Source	**Section L.3.b (p. 84)**	**Form C (p. 102)**
Self-Pay/Charity Care	1.24%	1.10%
Medicare	90.04%	90.00%
Medicaid	6.22%	6.15%
Private Insurance	2.49%	2.40%
Other (TRICARE)	0.41%	0.35%
Total	100.40%	100.00%

Without any explanation to reconcile the differences between payor mix for projected hospice admissions, the Bayada projections are unreliable. Therefore, the Bayada application does not conform to Criterion 13c.

Criterion 18a *"The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact."*

Based on the facts which result in Bayada being non-conforming with Criteria 1, 3, 5, 6, 7, 8, and 13c, it should also be found non-conforming with Criterion 18a.

Comments Regarding Comparative Analysis

Service to Rowan County Residents

Applications in this batch were filed in response to the 2020 State Medical Facilities Plan Need Determination for one additional hospice home care agency in Rowan County. CCNC proposes that 95.9% of its new (unduplicated) admissions in its Third Full Fiscal Year will be admissions of patients residing in Rowan County, the county for which the SMFP showed a need. By contrast, Bayada proposes that 87.1% of its new (unduplicated) admissions in the Third Full Fiscal Year will be admissions of patients residing in Rowan County.

Over 10% of new (unduplicated admissions) in Bayada's third project year are expected to be Stanly County residents. This projected service to 31 Stanly County residents in PY 3 represents a significant focus on Stanly County inasmuch as Stanly County, per the 2020 SMFP, reported a total patient deficit of only 33 patients.

In the 2018 Buncombe County Operating Room Review, Service to Residents of the Service Area was used as a Comparative Factor in the Agency's Comparative Analysis. In that Review, the Agency concluded that, generally, the application projecting to serve the highest percentage of Buncombe-Madison-Yancey

multicounty OR planning area residents is the more effective alternative with regard to this comparative factor since the need determination is for two additional ORs to be located in this multi-county service area. The Agency determined that the applicant projecting to serve the highest percentage of Buncombe-Madison-Yancey multicounty OR planning area residents during the third operating year was the most effective alternative. Similarly, in the 2019 Wake County MRI Review, Service to Residents of the Service Area was used as a Comparative Factor in the Agency's Comparative Analysis. In that Review, the Agency concluded that, generally, the application projecting to serve the highest percentage of Wake County MRI service area residents is the more effective alternative with regard to this comparative factor since the need determination is for one additional MRI to be located in the MRI service area. The Agency determined that the applicant projecting to serve the highest percentage of Wake County MRI service area residents during the third operating year was the most effective alternative.

As it did in the recent Buncombe OR Review and Wake County MRI Review, the Agency should conclude that the CCNC application is a more effective alternative than the Bayada application because CCNC projects to serve a higher percentage of Rowan County residents in the third operating year.

Costs & Revenues

As previously described, Bayada's operating costs and resulting revenues are not based on adequate hospice staff projections. See discussion regarding Criterion 7. Therefore, the conclusion of any comparative analysis of Bayada's costs and revenues would be inconclusive.

Also, it should be noted that on page 110, it states "BAYADA assumes that Service Intensity Add On Payments will be minimal and would not impact the above projected reimbursement rates." Therefore, a comparison of projected average net revenue per patient and per unduplicated admission between Bayada and CCNC would not be an "apples to apples" comparison. As described previously, CCNC's projected net revenue includes SIA payments which are separately itemized from its Medicare revenue by level of care. Therefore, CCNC's projected average net revenue per patient day and per patient are reflective of its commitment to provision of high quality, service-intense hospice services. Bayada's average net revenue per patient day and per patient may be comparatively lower due to the omission of SIA payments. By not including a revenue estimate for the SIA payment, and providing staffing levels that purport a high visit frequency, Bayada is inaccurately reporting their revenue.

Medically Underserved Access

As compared to CCNC's application, Bayada's proposal is inferior with respect to medically underserved access. Bayada projects comparatively lower charity care and Medicaid access than CCNC.

Access to a "New" Provider/Competition

The Agency evaluates access to a new provider in the context of the service at issue, here, hospice. While Bayada would be a new provider of hospice services in Rowan County, it is worth noting that Bayada already offers home health services in Salisbury, Rowan County and also operates Bayada Assistive Care

Services (personal care/aide services) and Bayada Pediatrics (home care) in Salisbury, Rowan County. Presumably, there will be overlap in the Bayada policies, procedures and potentially overlap in the leadership/personnel involved in the "old" and "new" Bayada operations in Rowan County.

By contrast, CCNC is new, not only to Rowan County, but to North Carolina. Patients and physicians will have the option to access a truly new alternative with CCNC.

Average Case Load Per Staff Discipline

As previously described, Bayada's Average Case Load projections are not supported; therefore, the comparative analysis of this factor is inconclusive.

COMMENTS SPECIFIC TO AMEDYSIS HOSPICE, LLC (Amedisys)
PROJECT ID No. F-011945-20

Criterion 1 *"The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which shall constitute a determinative limitation on the provision of any health services, health service facility, health service beds, dialysis stations, operating rooms, or home health offices that may be approved."*

POLICY GEN-3: BASIC PRINCIPLES states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

Amedisys fails to conform with Criterion 1 and Policy GEN-3 because the application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. The applicant does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. See discussion regarding criteria 3, 4, 5, 6, 8, 13c, and 18a. Therefore, the application is not conforming to this criterion and cannot be approved.

Criterion 3 *"The applicant shall identify the population to be served by the proposed project and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed."*

<u>Need Methodology</u>

The Amedisys Need Methodology overstates projected hospice deaths for Rowan County, resulting in utilization projections which are not reasonable nor supported. Consistent with the 2020 SMFP, CCNC identified the projected 2021 hospice deficit for Rowan County (159) and applied the two-year trailing average growth rate for hospice deaths statewide (2.3%) to project the number of unserved hospice deaths in Rowan County in each of its first three Project Years: 163, 167, and 170, respectively. By contrast, Amedisys projects 212, 233 and 256 unserved hospice deaths in Rowan County in FY 2022 through FY 2024. At the top of page 57 of its Application, Amedisys converts its projections to align with its project years, with the result being projections in the first three Project Years: 202, 228, and 250, respectively.

Unlike the methodology in the CCNC Application, the Amedisys projections do not reflect a reasonable and supported application of the two-year trailing average growth rate to the SMFP-projected hospice

deficit for Rowan County. Instead, Amedisys appears to have developed its projections using an average statewide penetration rate increasing at 1.3% annually. Because the Amedisys Application uses an overstated starting point for each of the Project Years, when it projects to capture a stated market share percentage in each of the Project Years, the resulting projections are unreasonable and unsupported.

If Amedisys had relied upon a forecast of unserved hospice deaths in Rowan County of 163, 167, and 170 in each of its first three Project Years and included the market share assumptions described on page 57 of its Application, the Amedisys utilization projections would be much lower than those forecasted on page 58 of its Application.

	Amedisys Projection PY 1	**Revised Projection PY 1**	**Amedisys Projection PY 2**	**Revised Projection PY 2**	**Amedisys Projection PY 3**	**Revised Projection PY 3**
Rowan Co.	202 x 40%= 74	163 x 40%= 65	228 x 80%= 182	167 x 80%= 134	250 x 90%= 225	170 x 90%=153

The Amedisys Application is not conforming to at least Criteria 3, 4, and 5 because projected utilization is not reasonable and is not adequately supported, as explained above.

Projected Utilization

The hospice agency proposed by Amedisys does not meet the need for hospice services in Rowan County nor does it represent an effective alternative.

Amedisys only projects to admit 90 total patients in its first year of operation. Across the year, this equates to less than 8 patient admissions per month of patients from all the Counties proposed to be served. Considering that Amedisys expects only 82.5% of its patients to originate from Rowan County, in its first full year of operation, Amedisys will be admitting only 74 total Rowan County patients or the equivalent of just over 6 patients per month.

As noted above, using reasonable and supported data, the Amedisys market share projections would indicate it would serve as few as 65 Rowan County residents in its first year, not even 6 patients per month. The SMFP identified a need for a new hospice agency in Rowan County considering data showing 159 unserved hospice deaths in Rowan County in FY2021, or the equivalent of over 13 patients per month. Thus, Amedisys in its first year (which extends halfway through 2022) will be serving less than half of the FY2021 unserved Rowan County deaths and providing only 3,902 days of care. Yet, Amedisys projects to provide over 20,300 days of care in its third year of operation. For the reasons described above, this projection is not reasonable and supported.

Throughout its first year, Amedisys will provide fewer than 4,000 days of care, falling well short of meeting the needs of the community; thereafter, its financial projections are premised on over-stated utilization projections exceeding 20,300 annual days of care.

The Amedisys proposal is not effective to meet the identified need. The project as defined is not the most effective alternative nor are its financial projections based on reasonable projections of utilization.

Access

In regard to Access, Section C.6 of the hospice CON Application form asks applicants to (1) describe "how" each of several groups will have access to the services proposed; and (2) to provide "the estimated percentage" of new (unduplicated) admissions in the third full fiscal year.

Per N.C. Gen. Stat. § 131E-182, application forms must require such information as the Agency, by its rules deems *necessary* to conduct the review. An Applicant is required to furnish only that information necessary to determine whether the proposed new institutional health service is consistent with the review criteria and with duly adopted standards, plans and criteria. In other words, the Agency can only ask for information it needs to conduct the review – when it fashions application questions, the Agency is defining what information it deems necessary. The information applicants are asked to provide is limited to information the Agency has determined to be *necessary* to show consistency with the review criteria.

Yet, instead of answering these two specific requests for information deemed necessary by the Agency for the conduct of this review, Amedisys provided a generalized discussion of its intentions for service to the identified groups without specifying "how" each group will have access.

Also, Amedisys provided different statistics than requested by the Application question. For example, Amedisys estimated that "as a percent of patient days," its proposed hospice agency would serve "1.2 percent low income persons" in the 3rd Fiscal Year. The Application asks for percentage of admissions. Moreover, Amedisys states that this 1.2 percent of patient days would be inclusive of both self-pay and charity care patients. Of course, self-pay patients are not necessarily low-income persons. Amedisys projects "27 percent of the patients" it serves will be minority patients. Again, this statistic does not respond to the question posed. Moreover, it is unclear why Amedisys identifies 24% of the population as minorities but projects minorities will represent 27% of its patients served. The balance of the Amedisys response is similarly non-responsive to the question as posed.

Per Criterion 3, the applicant must identify "the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed." This is the information sought by Question 6 in Section C. Without the necessary information sought by this question, an applicant cannot fairly be found conforming to Criterion 3.

Criterion 4 *"Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed."*

The Amedisys Application does not conform to Criterion 4. Amedisys does not adequately demonstrate that the alternative proposed in its Application is the most effective alternative to meet the need because Amedisys does not adequately demonstrate that projected utilization is based on reasonable and adequately supported assumptions. The Amedisys Application is not conforming to all statutory and regulatory review criteria. See discussion regarding criteria 1, 3, 5, 6, 8, 13c, and 18a. An application that cannot be approved cannot be the most effective alternative.

Also, Amedisys checked "No" on page 63 of its Application to indicate that there are no "alternative methods" of meeting the needs for the proposed project. As evidenced by the CCNC Application and, as a matter of common sense, there are clearly alternative methods to meet a projected need for a new hospice agency. For instance, Amedisys could have examined the alternative of meeting the need by proposing a hospice agency located in another part of Rowan County.

If Amedisys had indicated its ability to meet the need for the proposed project by proposing an agency in an alternate location, it could have then made a demonstration of why its proposed location was most effective. Having failed to acknowledge that alternative methods of meeting the need exist, Amedisys failed to make the required demonstration that its proposal was the least costly or most effective alternative. The burden is on the applicant to demonstrate conformity which Amedisys did not do.

Criterion 5 *"Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service."*

The Amedisys Application is not conforming to Criterion 5. The assumptions used by Amedisys in preparation of the pro forma financial statements are not reasonable and adequately supported because projected utilization is questionable. Since projected revenues and expenses are based at least in part on projected utilization, projected revenues and expenses are also questionable.

Availability of Funds

Amedisys identifies its parent company, Amedisys, Inc., as the entity that will provide accumulated reserves for the capital costs of its project. The CFO letter states funding of $168,556 will be provided through available cash. While neither the Amedisys Application nor its CFO letter state "cash on deposit will be available when needed," arguably, the CFO's description of his confidence in the parent company and its financial capacity are intended to convey an expectation that cash will be available when needed. That said, the Amedisys Application projects a need not just for $168,556 for capital costs but, separately, a need for **$1,004,529** in working capital to cover start-up expenses and expenses during the initial operating period.

The letter from the Amedisys CFO does not commit to provide $1,004,529. It states that in addition to the $168,556, it will provide "any" necessary working capital and additional funding.

Based on numerous sets of Agency Findings, the Agency routinely references in its Findings the amount of funding documented as available for a CON project. For instance, in the 2018 Mobile PET/CT Scanner Review, in finding an Applicant conforming to Criterion 5, the Agency stated:

> Exhibit F.2 contains a letter dated November 14, 2018 from the Vice President of Wells Fargo, committing to finance acquisition of the proposed mobile PET/CT scanner in an amount not to exceed $3,000,000. Exhibit F.2 also contains a letter dated November 15, 2018 from the Managing Member of PPI committing to use the funds from Wells Fargo for the proposed project. The

> applicant adequately demonstrates that sufficient funds will be available for the capital and working capital costs of the proposed project.

(emphasis added).

In the 2018 Durham County OR Review, even with a well-funded Applicant (Duke University Health Service) relying on accumulated reserves, the extent of the funding commitment was specifically identified and noted by the Agency in its Findings:

> Exhibit 9 contains a letter from DUHS' Chief Financial Officer committing up to $20 million accumulated cash reserves for the capital costs of the proposed project. DUHS' June 30, 2018 audited financial statement (Exhibit 9) shows cash and cash equivalents of $277,957,000, total current assets of $1,269,102,000 and total net assets of $3,619,728,000.

(emphasis added).

Amedisys has not put a certain amount of funds on deposit or committed a certain account to be available to fund the proposed project. Amedisys has not committed to provide "up to" a specified amount to fund this project. As a matter of common sense, no entity can make a *bona fide* commitment of funds with no limitations or parameters on the commitment. It is dubious for even the largest of corporate entities to pledge to provide funds of "any" amount to a subsidiary, particularly considering the significant on-going financial needs associated with the operation of an enterprise as large as Amedisys. The NC Court of Appeals has never held that a CON financing letter is sufficient when it identifies a capital cost requirement by reference to specific dollar amount but then commits to provide "additional funding" with no reference to an amount.

Form F.4 Errors

On page 60 of its application (Section C.7), Amedisys projects 19,585 Total Medicare & Medicaid days (18,568 + 1,017). Amedisys projects 6,880 Medicare & Medicaid days of care will be provided outside the patients' residence (6,569 + 311), which includes hospitals, inpatient hospice beds or residential hospice beds. This equates to 35.13% (6,880 ÷ 19,585) of the total combined number of days to hospice care furnished to Medicaid and Medicare patients provided outside the patient's residence which exceeds the 20 percent limitation described in 42 CFR 418.302(f)(2). Per 42 CFR 418.302(f)(2), at the end of a cap period, the Medicare Administrative Contractor calculates a limitation on payment for inpatient care to ensure that Medicare payment is not made for days of inpatient care in excess of 20 percent of the total number of days of hospice care furnished to Medicare patients. Based on the data provided on page 60 of its application, Amedisys clearly projects to exceeds the 20 percent limitation. Therefore, Amedisys inappropriately projects to collect revenue for the 2,963 days that exceed the 20 percent limitation (19,585 x .20 = 3,917) (6,880 - 3,917 = 2,963 days). For these reasons, Form F.5 reflects overstated revenues.

Form F.5 Errors

Amedisys projects it will incur an insurance expense of $8,400 during each of the first three project years. However, the proposed Agency would be expected to incur an escalating increase for insurance expenses during each project year based on the additional staff it projects to hire each year. For example, in Form

H Amedisys projects 10.3 total staff during Project Year 1, 18.8 total staff during Project Year 2, and 26.2 total staff during Project Year 3. The expense for workers compensation insurance would exponentially increase each year based on the incremental staff during Project Years 2 and 3.

Criterion 6 *"The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities."*

Amedisys failed to adequately demonstrate the need for the proposed services (See Criterion 3). Therefore, Amedisys failed to adequately demonstrate that its proposal will not result in an unnecessary duplication of existing or approved home health services and is nonconforming to this criterion.

Criterion 13c *"The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:*

> *(c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and*
>
> *(d) That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.."*

Per Criterion 13, an applicant must demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. To demonstrate conformity with subpart (c) of Criterion (13), the applicant must show that the elderly and medically underserved groups will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services.

As described previously, Amedisys provided no description of how the listed groups (i.e., low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, Medicare beneficiaries, and Medicaid recipients) would be expected to access services nor did it provide a single "estimated percentage" to identify the percentage of admissions in Year 3 which would be comprised of admissions of patients falling within each of the identified groups.

Per subsection (d) of Criterion (13), the applicant must show "means" of access such as access via physician referrals. This is the information sought by Question 6 in Section C. Without the necessary

information sought by this question (see discussion regarding Criterion 3), an applicant cannot fairly be found conforming to Criterion (13)(c) or (d).

Criterion 18a *"The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact."*

Based on the facts which result in Amedisys being non-conforming with Criteria 1, 3, 5, 6, 8, and 13, it should also be found non-conforming with Criterion 18a.

Comments Regarding Comparative Analysis

Service to Rowan County Residents

Applications in this batch were filed in response to the 2020 State Medical Facilities Plan Need Determination for one additional hospice home care agency in Rowan County. CCNC proposes that 95.9% of its new (unduplicated) admissions in its Third Full Fiscal Year will be admissions of patients residing in Rowan County, the county for which the SMFP showed a need. By contrast, Amedisys proposes that only 82% of its new (unduplicated) admissions in the Third Full Fiscal Year will be admissions of patients residing in Rowan County.

In the 2018 Buncombe County Operating Room Review, Service to Residents of the Service Area was used as a Comparative Factor in the Agency's Comparative Analysis. In that Review, the Agency concluded that, generally, the application projecting to serve the highest percentage of Buncombe-Madison-Yancey multicounty OR planning area residents is the more effective alternative with regard to this comparative factor since the need determination is for two additional ORs to be located in this multi-county service area. The Agency determined that the applicant projecting to serve the highest percentage of Buncombe-Madison-Yancey multicounty OR planning area residents during the third operating year was the most effective alternative. Similarly, in the 2019 Wake County MRI Review, Service to Residents of the Service Area was used as a Comparative Factor in the Agency's Comparative Analysis. In that Review, the Agency concluded that, generally, the application projecting to serve the highest percentage of Wake County MRI service area residents is the more effective alternative with regard to this comparative factor since the need determination is for one additional MRI to be located in the MRI service area. The Agency determined that the applicant projecting to serve the highest percentage of Wake County MRI service area residents during the third operating year was the most effective alternative.

As it did in the recent Buncombe OR Review and Wake County MRI Review, the Agency should conclude that the CCNC application is a more effective alternative than the Adoration application because CCNC projects to serve a higher percentage of Rowan County residents in the third operating year.

Access to a "New" Provider

The information provided in response to question 9 in Section A is confusing. The chart is difficult to decipher. The applicant indicates it is an existing provider of hospice services but responds to question 9(b).

Based on DHSR records, it appears Amedisys and Amedisys-related entities operate:

- Amedisys Hospice Care in Robeson County;
- Amedisys Hospice in Alamance County;
- Amedisys Hospice in Franklin County;
- AserCare Hospice in Pitt County;
- Amedisys Hospice in Wake County;
- Amedisys Hospice Care in Brunswick County; and
- Amedisys Hospice Care in Washington County.

The Agency evaluates access to a new provider in the context of the service at issue, here, hospice. While Amedisys would be a new provider of hospice services in Rowan County, it is worth noting that Amedisys already offers home health services in Rowan County and as well as in several nearby Counties.

Medically Underserved Access

As compared to CCNC's application, Amedisys's proposal is inferior with respect to medically underserved access. Amedisys projects comparatively lower charity care and Medicaid access than CCNC.

Average Caseload for Key Staff Disciplines

As compared to CCNC's application, Amedisys's proposal is inferior with respect to average caseload for key staff disciplines. Amedisys projects comparatively higher average caseloads for RNs, social workers, hospice aides, and chaplains than CCNC.

COMMENTS SPECIFIC TO HOSPICE OF IREDELL COUNTY, INC. (HOIC)
Project ID No. F-011948-20

Identity of Applicant

On page 1 of the CON Application, the Applicant is asked to provide its legal name and the name of its parent or holding company, if applicable. Hospice of Iredell County, Inc. ("HOIC") left blank the space to provide the name of its parent or holding company.

On page 7, HOIC states it "has received" a DBA to operate as Hospice & Palliative Care of Rowan County. HOIC says it "plans to operate" under a parent company DBA Pathways Hospice & Palliative Care, covering Iredell and Rowan Counties. Yet, on page 19, HOIC states it is "under the parent company of Pathways Hospice and Palliative Care."

According to the North Carolina Secretary of State, there is no corporation in North Carolina by the name "Pathways Hospice and Palliative Care." Likewise, there is no corporate entity by the name "Hospice and Palliative Care of Rowan County." There is no "Pathways Palliative Care of Rowan County." These are merely references to "DBA" or trade names, not actual corporate entities. Accordingly, per the Secretary of State's Office, the only *bona fide* legal entity associated with the HOIC CON Application is HOIC itself.

Criterion 1 *"The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which shall constitute a determinative limitation on the provision of any health services, health service facility, health service beds, dialysis stations, operating rooms, or home health offices that may be approved."*

POLICY GEN-3: BASIC PRINCIPLES states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

HOIC fails to conform with Criterion 1 and Policy GEN-3 because the application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. The application does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. See discussion regarding criteria 3, 4, 5, 6, 8, 13c, and 18a. Therefore, the application is not conforming to this criterion and cannot be approved.

Criterion 3 *"The applicant shall identify the population to be served by the proposed project and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed."*

Projected Patient Origin

HOIC failed to explain its projected patient origin. On page 16 of its CON Application, HOIC included a chart listing Rowan County, 238 admissions and a total of 27% and a line under the chart stating "25.2% representative of total hospice admissions by all providers in FY 2023-2024."

HOIC appears to simply assume it will serve ALL of the difference between 638 patients deaths served by other hospice providers and its projection of 850 deaths based on 44.5% of deaths served by hospice applied to the total Rowan County population. The text under the chart referencing 25.2% is not well-explained nor related to the projections above. In other words, HOIC's patient origin – apparently 100% Rowan County residents although not so specified in the chart – is presented without any assumptions or methodology supporting the projection that HOIC will itself serve all additional deaths in the County. The text refers to an Exhibit C.1 but there is no Exhibit C.1 in the Table of Contents and the materials provided do not relate to market share or the HOIC projections.

In the 2018 Forsyth County OR Review, in analyzing the Application submitted by Novant Health, Inc. and Forsyth Memorial Hospital, Inc., the Agency found that "the figures as provided in the application and shown in the two tables … are not accurately totaled and do not provide accurate percentages." The Agency determined that "the numbers of patients, calculation totals, and/or percentages are incorrectly calculated and/or totaled. The information in the application as submitted is not sufficient to allow the Project Analyst to determine where the errors lie. Is the total number to be served correct and the individual county numbers wrong? Are the individual county numbers correct and the total incorrect? Are the percentages accurate and just not distributed and totaled correctly? There simply is not enough information provided in the application as submitted to make a determination." The Agency Findings concluded "the applicant has not adequately identified the population to be served." Unlike the 2018 Forsyth County OR Review, HOIC is not an existing provider in Rowan County and has no historical patient origin for a Rowan County hospice agency. Therefore, the application failed to adequately identify the population to be served by the proposed project and the application does not conform to Criterion 3.

Need

In FFY2019, HOIC's Iredell County hospice home care office (HOS0387) served 6 hospice patients in Rowan County. HOIC failed to demonstrate in its application that the Rowan County residents it proposes to serve need HOIC to locate an office in Rowan County as opposed to HOIC continuing to provide services to Rowan County residents from its Iredell County hospice office (HOS0387). The Application included no information to explain why the Applicant's Iredell County hospice home care office is unable to serve the projected Rowan County hospice deaths. Further, HOIC did not demonstrate that the proposed hospice services would not duplicate the services provided by its Iredell County hospice office given the number of Rowan County patients the applicant proposes to serve at the Rowan County hospice home care office.

Criterion 4 *"Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed."*

The CON Law provides:

No person shall incur an obligation for a capital expenditure which is a new institutional health service without first obtaining a certificate of need from the Department. An obligation for a capital expenditure is incurred when:

> (1) An enforceable contract, excepting contracts which are expressly contingent upon issuance of a certificate of need, is entered into by a person for the . . . lease or financing of a capital asset.

. . . .

N.C. Gen. Stat. § 131E-178(c)(1).

On pages 7-8 of its Application, HOIC lists the address of its proposed facility as 1121 Old Concord Road, Salisbury, Rowan County, NC, 28146. In Exhibit F.3.2 to its Application, HOIC includes a Commercial Lease Agreement for the property at this address **which it has already executed, and which went into effect as of September 1, 2020**. The Lease Agreement is not contingent upon issuance of a CON to HOIC for the proposed hospice agency; in fact, it appears that HOIC has been making lease payments on the property for several months. Notably, HOIC cannot suggest it will only use the property for its proposed hospice agency if granted CON approval, as Section 8 of the Lease Agreement lists "Hospice & Palliative Care" as the only permitted use of the property.

On these facts, HOIC has violated the CON Law before this Review has even begun: it has "incurred an obligation for a capital expenditure" by "entering into [a] lease . . . of a capital asset" (namely, the building which will house the proposed hospice agency) without first obtaining a CON. *See id.* An Application proposed in contravention of the CON Law cannot be the most effective alternative; HOIC is non-conforming with Criterion 4.

Also, HOIC checked "No" on page 23 of its Application to indicate that there are no "alternative methods" of meeting the needs for the proposed project. As evidenced by the CCNC Application and, as a matter of common sense, there are clearly alternative methods to meet a projected need for a new hospice agency. For instance, HOIC could have examined the alternative of meeting the need by proposing a hospice agency located in another part of Rowan County.

If HOIC had indicated its ability to meet the need for the proposed project by proposing an agency in an alternate location, it could have then made a demonstration of why its proposed location was most effective. Having failed to acknowledge that alternative methods of meeting the need exist, HOIC failed to make the required demonstration that its proposal was the least costly or most effective alternative. The burden is on the applicant to demonstrate conformity which HOIC did not do. For this additional reason, HOIC should be found non-conforming with Criterion 4.

The HOIC Application is not conforming to Criterion 4. HOIC does not adequately demonstrate that the alternative proposed in its Application is the most effective alternative to meet the need because the

Application is not conforming to all statutory and regulatory review criteria. See discussion regarding criteria 1, 3, 5, 6, 8, 13c, and 18a. An application that cannot be approved cannot be the most effective alternative.

Criterion 5 *"Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service."*

As discussed under Criterion 4 above, HOIC has violated the CON Law before this Review has even begun by entering into (and performing under) an enforceable Lease Agreement to rent the building (a capital asset) for its proposed hospice agency. *See* N.C. Gen. Stat. § 131E-178(c)(1); *see also id.* at § 131E-190. The penalty for such violation can include "a civil penalty of not more than twenty thousand dollars ($20,000) . . . whenever [the Agency] determines a violation has occurred and each time the service is provided in violation of this provision." *Id.* at § 131E-190(f).

Because the Agency may be inclined to assess HOIC a civil penalty of up to $20,000 for "jumping the gun" on the lease for its proposed hospice agency, HOIC's projection of availability of funds for working capital is questionable. HOIC proposes it will need $25,495.96 in working capital; even a minor civil penalty would render HOIC unable to demonstrate the availability of sufficient funds to meet these needs. For this reason, HOIC is non-conforming with Criterion 5.

<u>Form F.1a Errors</u>

Criterion 5 requires, among other things, that financial feasibility be demonstrated on the basis of reasonable projections of costs. HOIC's cost projections are not reasonable and adequately supported and thus, it failed to make the showings required by Criterion 5.

The HOIC capital costs are not reasonable and supported. HOIC states it will expand an existing office to provide hospice services, but it does not project any cost associated with adding any improvements, equipment or furniture to the space it currently uses for its palliative care operations. Without further explanation, it is not reasonable or supported for HOIC to suggest it can add an array of staff to allow it to operate a hospice agency without acquiring any additional equipment or furniture for those staff persons to utilize in the existing office space.

HOIC appears to have mistakenly completed the Form F.1a Capital Cost form. On Form F.1a, HOIC lists its projected start-up expense of $25,495.96 which it indicates is solely for "employee hiring and training." This cost is not properly included on Form F.1a.

Form F.1a thus includes zero in true capital costs. Nonetheless, HOIC states that all "monies needed for Capital Cost will be pulled from HOIC accumulated reserves." This creates confusion over whether HOIC actually did intend to incur some capital costs for its project – as noted above, it is unreasonable to assume new staff could be hired to work in an already-operational office without any new desks, chairs, phones, etc. HOIC states the office "would easily be expanded" but does not explain how it can expand the office

with zero capital costs. The project will logically require costs such as computers for hired staff, licensing, accreditation, and other startup related costs other applicants have identified.

HOIC states that it will require $25,495.96 for "new employee hiring and training" and that no additional start-up costs are anticipated.

Based on the limited information supplied by HOIC, its projections for start-up costs are not reasonable and adequately supported. HOIC does not explain how new staff can be hired and trained without HOIC expending any money for the rent and utilities associated with the space where the newly hired staff will be hired and trained. The existing Palliative Care operation cannot simply "donate" space to the new HOIC hospice. HOIC's new hospice will have to occupy space in which to provide new employee hiring and training activities – as such, absent some explanation, the costs associated with doing so (e.g. rental expense, utilities, and supplies) must be included for the project costs to be reasonable.

Available Funds

The HOIC Application does not make the showings required under Criterion 5 to document availability of funds.

Capital Cost

The Legal Applicant is "Hospice of Iredell County, Inc." The other names sprinkled throughout the HOIC Application are merely trade names, not the names of actual legal entities. HOIC states that all monies needed for Capital Cost "will be pulled from HOIC accumulated reserves." Yet, on the top of page 26, in the chart labeled "Sources of Capital Cost Financing," the name "Hospice and Palliative Care of Rowan County" is listed.

Hospice and Palliative Care of Rowan County is not an entity, and nothing documents that it has any accumulated reserves. To the extent this entity is different than HOIC, the Legal Applicant, nothing documents that this entity has committed funds to HOIC.

Despite the identification of Hospice and Palliative Care of Rowan County as the Source of Capital Cost Financing, if it is assumed funds will come instead from HOIC, there is nothing to document that HOIC has sufficient funds available.

The HOIC Application did not provide pro formas or any other type of financial statement, such as a balance sheet or consolidated financial statements, which would adequately demonstrate the availability of sufficient funds. This is the same issue that caused the Agency to find a non-conformity in the 2018 Buncombe County Operating Room Review.

In fact, HOIC did not provide even a letter from HOIC attesting to the availability of funds to cover start-up expenses. There is nothing within the Application or Exhibits to document that HOIC has accumulated reserves reasonably likely to be available when needed, in sufficient amounts. The only statement is that accumulated reserves are available, and some certificates of deposit are also available. This vague statement is made in the section speaking of sources of financing for "Capital Cost" of which HOIC (unreasonably) identifies none.

Start-Up & Initial Operating Expenses

As noted above, HOIC understates the start-up costs necessary for its project by failing to project cost for categories of essential costs without explanation. HOIC projects to need $25,495.96 in start-up expenses plus another $170,329 in initial operating expenses for a total of $195,824.96.

Notably, HOIC failed to include obligations of rental expense in its projections of startup expenses. As shown on beginning on PDF page 54 of its Exhibit book, HOIC entered into a lease agreement with 6814 Construction, LLC. The terms of the lease commence on 09/01/2020 and HOIC agrees to pay the landlord an annual rental rate of $11,400, payable in equal monthly installments of $950.00. Per Section P (page 57), HOIC does not propose to begin offering hospice services until 04/04/2021; therefore, HOIC failed to account for $6,650 in startup expenses (7 months x $950) attributable to lease expense obligations in advance of the proposed service offering.

HOIC states the following regarding the source of funds: "The parent company of Hospice & Palliative Care of Rowan County, Pathways Hospice and Palliative Care is prepared and approved by the board of directors to absorb the negative net income from the first year and half of operations."

This showing does not satisfy the Criterion 5 requirement. Per the Secretary of State, there appears to be no entity in North Carolina by the name Pathways Hospice and Palliative Care.

Pathways did not provide pro formas or any other type of financial statement, such as a balance sheet or consolidated financial statements, which would adequately demonstrate the availability of sufficient funds. This is the same issue that caused the Agency to find a non-conformity in the 2018 Buncombe County Operating Room Review.

The statement that Pathways will "absorb the negative net income" is wholly insufficient. Funds for start-up expenses must exist before operations – here, nothing shows that funds will be available when needed.

Pathways is not the Legal Applicant. If Pathways wanted to provide funds to HOIC, it would have to provide a written commitment to provide those funds, document that it had sufficient funds, and indicate the funds would be available when needed. HOIC, in turn, would have to indicate that it would receive the funds from Pathways and would commit them to this project. However, none of that required documentation is included in the HOIC CON Application or Exhibits. In cases where the project is to be funded other than by the applicants, the application must contain evidence of a commitment to provide the funds by the funding entity. Without such a commitment, an applicant cannot adequately demonstrate availability of funds or the requisite financial feasibility. Ret. Villages, Inc. v. N. Carolina Dep't of Human Res., 124 N.C. App. 495, 499, 477 S.E.2d 697, 699 (1996). HOIC plainly fails to show conformity with Criterion 5.

Form F.4 Errors

HOIC projects equivalent continuous care revenue during each project year; however, the Applicant projects continuous care hours will increase from Project Year 1 to Project Year 2.

HOIC failed to provide the assumptions or calculations to reflect whether it used a blended reimbursement rate to project hospice revenues. Form F. 3 provides reimbursement rates for days 1-60 and 61+; however, it is not clear what rate the Applicant used to project revenues in Form F.4.

Form F.5 Errors

As described previously, HOIC they failed to include any capital costs for necessary computers for hired staff, licensing, accreditation, and other related costs. Both Capitalization Requirements and expenses related to Depreciation/Amortization could be understated or not met.

HOIC projects no increase in its annual rent expense.

Nursing Home Room & Board

A Medicare-certified/NC Licensed hospice agency is able to provide hospice services in a nursing home facility where the recipient can be dually eligible for Medicaid where Medicaid covers the cost of the patients nursing home room and board less any patient share of cost. In North Carolina, the hospice agency must bill NC Medicaid for the room & board charges and in turn the hospice receives reimbursement at 95% and less any patient share of cost and Medicare pays the hospice for the hospice benefit. A hospice provider must have a contract with a nursing home if services are provided within those facilities which will include the guidance on how the nursing home room and board is handled including compensation.

In November 1997, the Office of the Inspector General reported on Hospice and Nursing Home Contractual Relationships and identified in their findings that "*Almost all hospices reviewed pay nursing homes the same or more than what Medicaid would have paid for nursing home care if the patient had not elected hospice.* " https://oig.hhs.gov/oei/reports/oei-05-95-00251.pdf With that being said, **there would be an expense created for the hospice of at least 5% which should be reported in the financials as a cost**. The basis for this cost would be the percentage of patients the hospices serve in nursing homes. NHPCO-Facts-Figures-2020-edition reported that at least 17.27% of patient's location of care is in a nursing facility. Similarly, based on the 2020 Hospice Data Supplements for the hospice offices located in Rowan County, approximately 19.9% of patients' care was provided in a nursing facility during FFY2019. Please see the following table.

Location of Care	Trellis Supportive Care (HOS2425)	Novant Health Hospice (HOS4599)	Combined Total	% of Total
Home	169	182	351	73.2%
Nursing Facility	74	53	127	19.9%
Hospice Unit		-	-	0.0%
Hospital		-	-	0.4%
Hospice IP Facility		-		-
Residential	34	17	51	6.6%
Total	277	252	529	100.0%

Source: 2020 Hospice Data Supplements, Section D, page 4

Therefore, based on the historical experience of hospice offices located in Rowan County, one can reasonably project that some percentage of patients will be served in a nursing facility. However, HOIC failed to identify any costs for Room & Board expense in Form F.5 Operating Costs.

For the aforementioned reasons, all applicants providing hospice services should include charges and expenses related to Nursing Home Room & Board passthrough. In reporting this expenditure for the CON, CCNC identified this expenditure as Room & Board Expense on Form F.5. Operating Costs. In addition, CCNC identified inpatient costs for respite and GIP stays at contracted facilities on the same form. Of the seven applicants in the Rowan Count hospice batch review, only two applicants (CCNC and Amedisys) identified that there was an expense related to servicing patients in a facility.

GIP & Respite Care

When GIP & Respite care is provided in a facility, a hospice must be contracted with a nursing facility, hospital or hospice inpatient facility in order to provide services to patients at those levels of care unless the agency operates their own hospice inpatient facility. HOIC does not indicate in Form F.5 Operating Costs or Assumptions that there is a charge for the contracted rates to facilities. In Project Year 3, HOIC indicates that there will be 854 Inpatient Care Days, and 74 Respite Care Days ($887,035 total Revenue) Therefore, if HOIC projects to provide hospice days of care at both levels of care, Form F.5 Operating Costs should similarly reflect the facility costs to provide the services.

Though HOIC operates Gordon Hospice House (a 15-bed facility) in Statesville, the location of the facility is outside of Rowan County and would negatively impact the utilization of inpatient beds for Iredell County residents. Additionally, the access by service area residents would be restrictive and the costs to provide the services in the out-of-county facility should be identified as intercompany passthrough charges which are not included in HOIC's assumptions.

HOIC's projected operating costs are not reasonable and adequately supported because Form F.5 failed to include applicable Room & Board expense for hospice services provided in a nursing home, including costs for respite and GIP care.

Consequently, HOIC does not conform to Criterion 5.

Criterion 6 "The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities."

HOIC did not demonstrate that the proposed hospice services would not duplicate the services provided by its Iredell County hospice office. See discussion regarding Criterion 3.

Criterion 18a *"The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-*

effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact."

Based on the facts which result in HOIC being non-conforming with Criteria 1, 3, 5, and 6, it should also be found non-conforming with Criterion 18a.

Comments Regarding Comparative Analysis

Costs & Revenues

As previously described, HOIC's operating costs and resulting revenues do not include applicable Room & Board expenses. See discussion regarding Criterion 5. Therefore, the conclusion of any comparative analysis of HOIC's costs and revenues would be inconclusive.

Medically Underserved Access

As compared to CCNC's application, HOIC's proposal is inferior with respect to medically underserved access. HOIC projects comparatively lower charity care and Medicaid access than CCNC.

Access to a "New" Provider/Competition

HOIC's proposal is the least effective alternative with respect to access to a new provider. HOIC provides hospice services to Rowan County patients via its Iredell County hospice office (HOS0387). HOIC will not facilitate access to a new hospice provider for Rowan County hospice patients.

Average Caseload for Key Staff Disciplines

As compared to CCNC's application, HOIC's proposal is inferior with respect to average caseload for key staff disciplines. HOIC projects comparatively higher average caseloads for RNs, social workers, hospice aides, and chaplains than CCNC.

COMMENTS SPECIFIC TO ADORATION HOME HEALTH & HOSPICE INC. (Adoration)
PROJECT ID No. F-011949-20

Criterion 1 *"The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which shall constitute a determinative limitation on the provision of any health services, health service facility, health service beds, dialysis stations, operating rooms, or home health offices that may be approved."*

POLICY GEN-3: BASIC PRINCIPLES states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

Adoration fails to conform with Criterion 1 and Policy GEN-3 because the application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. The applicant does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. See discussion regarding criteria 3, 5, 6, 7, 8, 13c, and 18a. Therefore, the application is not conforming to this criterion and cannot be approved.

Criterion 3 *"The applicant shall identify the population to be served by the proposed project and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed."*

Adoration projects that over 40 percent of its unduplicated admissions will be Stanly County residents. Adoration fails to demonstrate conformity with Criterion 3 because the applicant's assumptions and methodology used to project its patient origin are not reasonable and adequately supported. The SMFP showing of a deficit in Stanly County reasonably supports a projection to serve a modest number of Stanly County residents from a hospice location in neighboring Rowan County. But, considering its projection that Stanly County residents will comprise fully 43 percent of its Year Three admissions, Adoration needed to provide something more to adequately support and substantiate the reasonableness of its projection.

By including such a high projection of admissions from Stanly County (without adequate support), Adoration factors in a lower rural reimbursement rate for Medicare and Medicaid beneficiaries. For reimbursement, Rowan County is considered part of a Metropolitan Statistical Area that includes Charlotte and other area locations. Stanly County's rates are in the "All other Rural Counties" category in

which rates are lower than those set for locations within the Charlotte MSA. Without reasonable and adequate support, Adoration uses a patient origin projection that inflates the percentage of admissions of Stanly County residents and by doing so, Adoration is able to show lower revenue projections than would be associated with a reasonable projection of admissions of residents of Rowan and Stanly Counties.

Further, the Adoration application relies on unreasonable projections of hospice deaths to project utilization for the proposed project. Beginning on page 88 of its Application, Adoration describes its method of calculating a Median Percent of Deaths Served for the "SURROUNDING COUNTIES", which includes Cabarrus, Davidson, Davie, Gaston, Iredell, Mecklenburg, Rowan, Stanly, and Union counties. On page 90, Adoration states the FFY2018 and FFY2019 Median Percent of Deaths Served for the "SURROUNDING COUNTIES" is 48.94% and 48.90%, respectively. This are considerably higher compared to the FFY2018 statewide Median Percent of Deaths Served (44.5%). Adoration's methodology proceeds to inflate the Median Percent of Deaths Served for the "SURROUNDING COUNTIES" by applying the two year trailing average annual growth rate in Median Percent of Deaths Served by Hospices for the "SURROUNDING COUNTIES".

Adoration failed to provide any rationale to support the reasonableness of its assumption that the percent of deaths served by hospice in Rowan County will far exceed the statewide median percent of deaths served by hospice. In fact, on page 91 of its application Adoration admits "the Median Percent of Deaths Served for the SURROUNDING COUNTIES is significantly higher than the Statewide Median Percent of Deaths Served." The following table, included on page 91 of the Adoration Application, illustrates the disparity between the Statewide Median Percent of Deaths Served and the Median Percent of Deaths Served for the SURROUNDING COUNTIES.

	2018	**2019**
Statewide	42.69%	39.63%
SURROUNDING COUNTIES	48.06%	50.23%

Utilizing the Median Percent of Deaths Served for the SURROUNDING COUNTIES results in a gross overstatement of the Median Projected 2021 Hospice Deaths and 2022 Hospice Deaths in Rowan County. Adoration's decision to substitute the Median Percent of Deaths Served for the SURROUNDING COUNTIES into the calculation of the Median Projected 2021 Hospice Deaths and Median Projected 2022 Hospice Deaths (see Table C.7, Column I, and Table C.8, Column I on pages, 92 and 93, respectively) results in a projected 302 and 257 Additional Patients in Need for Rowan and Stanly Counties in 2021 and 2022. On page 94 of its Application, Adoration applies its market share projections to the grossly overstated projected hospice deaths in Rowan County and Stanly County, respectively. However, the resulting hospice deaths are not based on reasonable and supported assumptions. For the reasons previously described. Therefore, the projected hospice days of care are not reliable because they are premised on patient projections which are unfounded and not achievable.

Consequently, Adoration's projected numbers of patients, deaths served, ALOS and days of care are not reasonable, credible, or supported. Therefore, the applicant does not adequately demonstrate the need

the projected population has for the proposed hospice home care office. Consequently, the application is not conforming to this criterion.

Criterion 4 *"Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed."*

The Adoration application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. An application that cannot be approved cannot be an effective alternative.

The applicant does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. Therefore, the application is not conforming to this criterion and cannot be approved. See discussion regarding criteria 1, 3, 5, 6, 7, 8, 13c, and 18a.

Criterion 5 *"Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service."*

Discrepancies in Start-Up and Working Capital Projections

The Adoration Application contains several discrepancies and errors which result in its failure to adequately demonstrate funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal.

At the top of page 54, responsive to Section F.3(a) of its Application, Adoration identifies a 150 day estimated start-up period. After identifying a 150-day start-up period, Adoration explains:

> " … costs are allocated based on the number of days in the start-up period."

Using the above assumption/methodology, Adoration presents its projected costs for certain staff salaries, staff benefits and taxes, medical and office supplies, rent and utilities for Project Year 1 and then multiplies the total of those projected costs by .4110 to identify 150-days of associated costs.

Total Projected Costs x 150/365 (41.10%) = Total Start-Up Expenses

$761,076 x .4110 = $312,771

Yet, at the bottom of that same page (54), in response to Section F.3(d), Adoration states its estimated start-up expenses are based, not on 150 days, but on 60 days of staff salaries, staff benefits and taxes, medical and office supplies, rent and utilities. Using the 60-day assumption and methodology Adoration identifies in response to Section F.3(d), Adoration would need only $117,651 in funds for start-up expenses:

Total Projected Costs x 60/365 (16.43%) = Total Start-Up Expenses

$761,076 x .1643 = $117,651

Adoration's Application is likewise inconsistent with respect to Initial Operating Expenses. In response to Section F.3(b), Adoration states that its initial operating period will be 150 days. Total Operating Costs in Year 1, as identified on Form F.5, are $983,945. Using approximately 41% of that number, Adoration identifies $404,361 as its estimate of total expenses for the initial operating period.

Total Cumulative Operating Costs x 150/365 (41.10%) = Total Start-Up Expenses

$983,945 x .4110 = $404,303

Yet, in response to Section F.3(d), Adoration states its estimated start-up expenses are based, not on 150 days, but on 90 days of total cumulative operating costs from FY 1. Using the 90-day assumption and methodology Adoration identifies in response to Section F.3(d), Adoration would need only $242,542 in funds for start-up expenses:

Total Projected Costs x 90/365 (24.65%) = Total Start-Up Expenses

$983,945 x .2465 = $242,542

Using the assumptions and methodology in response to Section F.3(d), Adoration would only need $360,193 in working capital.

$117,651 + $242,542 = $360,193

However, using the assumptions and methodology in response to Section F.3(a), Adoration would need $ 717,074 in working capital.

$312,771 + $404,303 = $717,074

Thus, one estimate of working capital needs is over $717,000 and the other is only $360,000.

Despite the conflicting estimates of working capital needs (a difference of ***over $350,000***) in response to Section F.3(a) and F.3(d)(page 54), Adoration confirms in Section F.3(e) (page 55) that its project will require $717,132 in working capital and that it intends the funding source for these needs to be "accumulated reserves."

Perhaps as a result of relying on the 60-day and 90-day assumptions and methodology which appear to have been mistakenly identified on page 54 of the Adoration CON Application, Adoration includes a financing letter which assumes the working capital needs for the project will be "***up to $375,420***," not over $700,000.

Specifically, in Exhibit F.2, Kevin Fisher, the Vice President of Finance and Treasurer of the BrightSpring family of entities, provides "Documentation of Availability of Funds for Adoration's Proposed Rowan County Hospice Agency" in which he states that the "working capital required for the proposed project is estimated to be ***up to $375,420***."

The working capital needs described in the financing letter are, thus, **understated** by over $350,000. Fisher's description of the working capital needs appears to relate to the erroneous 60- and 90-day projections calculated above but **not** to the actual estimate of ***$717,074*** in working capital requirements

identified on pages 54 and 55 of the Adoration CON Application. The funding letter describes working capital needs of up to $375,420 but never once references the projected requirement for over $700,000 in working capital funds per pages 54 and 55 of the Adoration Application.

Adoration will no doubt seek to down-play its error by pointing out that Fisher's letter goes on to state that BrightSpring commits to provide all proposed funds plus "any additional, should they be required." As a matter of common sense, no entity can make a *bona fide* commitment of funds with no limitations or parameters on the commitment.

North Carolina's Court of Appeals has never held that a CON financing letter is sufficient when it identifies capital cost and working capital requirements by reference to specific dollar amounts but then commits to provide those amounts plus "any additional" amount. It is dubious for even the largest of corporate entities to pledge to provide funds of "any" amount to a subsidiary, particularly considering the significant on-going financial needs associated with the operation of an enterprise as large as BrightSpring.

Adoration's Showing of "Available" Funds is not a Reasonable Showing

In an effort to document available funds, Adoration does not indicate that a parent or related entity has put specific funds on deposit for capital and working capital needs of the proposed project.

Instead, Adoration submits a letter stating that a parent company of the Applicant has its own checking account with funds it commits to provide to Adoration. Fisher references a BrightSpring checking account with an available cash balance of $4.4 million.

At first blush, the significant sums referenced by Fisher would seem to suggest that more than adequate funds are available despite the discrepancy between Adoration's professed need for over $700,000 in working capital funds and the financing letter reference to a working capital requirement of only "***up to $375,420***." However, a more careful examination shows Adoration failed to demonstrate conformity with Criterion 5.

Adoration states BrightSpring has a checking account with a "cash balance" of $4.4 million, the vast majority of which will be available at project implementation. To substantiate this assertion, Adoration attaches one page of a sixty-page bank statement showing an account in the name of Res-Care, Inc., a parent company of the applicant entity.

The fragment selection of the bank statement included in the Adoration CON Application in Exhibit F.2 shows significant sums of money flowing in and out of a single bank account in the name of Res-Care. For example:

- The one-month bank statement shows the account with a "beginning balance" of $2.92 Million and an "ending balance" of $4.38 Million.
- On the first day of the month, the account shows a $4.6 Million wire transfer.
- In the middle of the month, one line inexplicably labeled "Zero Balance Transfer" is a transaction in the amount of $2.6 Million.

- Also at the outset of the month, the statement shows a single line transaction wire of $8.6 Million in funds noted as "Orig: Pharmerica Corp."

In fact, the bank statement purports to show that $262 million dollars were deposited into the account in a single month and $261 million in debits were made against the account in that same time period. The account shows over 400 deposits and over 970 debits in a single month.

While the numbers are large, even a brief inspection shows a bank account with ***multi-million dollar fluctuations*** over the course of a relatively few days, including hundreds of millions in deposits and debits and a $1.4 million total balance swing in the account within a single month.

With this information, the sentence in Fisher's letter suggesting that the "vast majority" of the account balance of $4.4 Million will be intact at project implementation is highly questionable. In fact, at the outset of the short time frame depicted by the single page of the Res-Care bank statement, the account had only about 65% of that referenced sum on deposit. Obviously, this checking account is one that experiences constant fluctuations and wide-ranging swings in total funds on deposit. The funds in this account are plainly not funds set aside for the benefit of a Rowan County hospice project by this Adoration subsidiary but rather this account is in constant play as some form of "sweep" account with money apparently coming in and out to a number of entities.

Fisher also refers to a credit line of $320 million held by "Phoenix Guarantor." Documentation of the $320 million revolving line of credit should be similarly disregarded because the Fisher letter and the attached Morgan Stanley letter both fail to state whether the line of credit will even be open on the date on which the proposed project will require "additional" funding.

Neither the Fisher letter nor the Morgan Stanley letter document that the line of credit will be available when needed because neither letter states when the line of credit expires. The only date reference (other than to when the credit line was originally entered) is a reference to a "maturity date." The maturity date for a line of credit is simply the date the money loaned must be fully repaid. In other words, the maturity date is the final repayment date, not the date through which the line of credit is available to the borrower.

In Johnston Health Care Ctr., L.L.C. v. N. Carolina Dep't of Human Res., 36 N.C. App. 307, 319, 524 S.E.2d 352, 360 (2000), our Court of Appeals upheld the Agency's determination that Johnston Center failed to establish the availability and commitment of funds required under Criterion 5 when the applicant relied on a line of credit that would expire before the commencement of the proposed project. The Court held that this fact constituted substantial record evidence supporting the Agency's finding that Johnston Center's application failed to conform to Criterion 5.

Moreover, the Fisher letter is problematic in that it baldly states that the applicant's re-payment of sums borrowed through the line of credit would have "no material impact" on Adoration's financial projections for this project. By this choice of words, Fisher confirms that Adoration would have to repay the Morgan Stanley line of credit loan at an interest rate of Libor + 4.25%. No amortization schedule is included in the Adoration CON Application nor is there any information to confirm the period of time over which Adoration would be expected to repay the loan.

As noted above, the Morgan Stanly letter does reference a maturity date of March 5, 2024 which falls during Adoration's projected Project Year 3 (PY 3). If Adoration re-paid the credit line loan during PY 1 – 3, it would be required to pay approximately $142,250 per year.

Loan Summary

PRINCIPAL	INTEREST RATE	LENGTH
$400,000	4.25%	3 years

Payment Summary

NUMBER OF PAYMENTS	MONTHLY PAYMENT	TOTAL PRINCIPAL PAID	TOTAL INTEREST PAID	TOTAL PAID
36	**$11,854.13**	$400,000.00	$26,748.69	$426,748.69

Yearly Amortization Schedule

PAYMENTS	YEARLY TOTAL	PRINCIPAL PAID	INTEREST PAID	BALANCE
Year 1 (1-12)	$142,249.56	$127,718.35	$14,531.21	$272,281.65
Year 2 (13-24)	$142,249.56	$133,253.37	$8,996.19	$139,028.27
Year 3 (25-36)	$142,249.56	$139,028.27	$3,221.29	$0.00
	$426,748.69	**$400,000.00**	**$26,748.69**	

Obviously, Adoration's financial projections did not take into account a re-payment obligation. Adoration calculated its initial working capital needs without factoring in any sums for re-payment of a line of credit loan. Based on the re-payment totals referenced above, Adoration would need about another $60,000 in the first five months to re-pay a loan of $400,000. This would be extra working capital money which would mean it needed a larger loan and would have a higher re-payment obligation. The bottom-line is that Adoration cannot attempt to rely on funding from a credit line and just brush aside the re-payment obligation by simply declaring it would have "no material impact."

In the 2018 Buncombe County Operating Room Review, the Agency concluded that one of the applicants in the competitive batch review did not adequately demonstrate the availability of sufficient funds for the capital needs of its project because it did not account for repayment of a loan referenced in its application. The Agency noted that, as here, the applicants did not provide an amortization schedule for a forecasted loan. An amortization schedule was prepared by the Project Analyst to show the amount of repayment the applicant would be responsible for in the first year of repayment. Just as here, the Agency noted that there were no line items in Form F.3, or anywhere else in the pro formas provided by the applicants to account for re-payment expense or to explain how the applicant would repay the loan.

In the 2018 Buncombe County Operating Room Review, the applicants likewise did not provide pro formas or any other type of financial statement, such as a balance sheet or consolidated financial statements, which would adequately demonstrate the availability of sufficient funds to pay off the loan. In the absence of such financial documentation, the Agency found the applicant did not adequately demonstrate the availability of sufficient funds for its project.

The Adoration CON Application does not provide any financial information for the Applicant to document any independent ability to pay off a loan. The Adoration Application has no pro formas or any other type of financial statement (such as a balance sheet or consolidated financial statements) to demonstrate that Adoration could re-pay funds drawn on the Phoenix Guarantor line of credit. In the absence of such, Adoration cannot rely on the line of credit to demonstrate available funds.

Lack of a Commitment from Adoration to use Funds for its Project as Proposed

Per Criterion 5, an applicant must show funds are "available" to the applicant ***and*** "and committed" by the applicant to the project as proposed. *Dialysis Care of N. Carolina, LLC v. N. Carolina Dep't of Health & Human Servs.*,137 N.C. App. 638, 642, 529 S.E.2d 257, 259, aff'd, 353 N.C. 258, 538 S.E.2d 566 (2000).

By way of example, in the *Caldwell Memorial* case, our Court of Appeals expressly noted that co-applicant SCSV, LLC provided a letter which stated SCSV, LLC was committed to utilizing the funding provided by the bank to develop the proposed facility. The Court separately noted that co-applicant Caldwell Memorial provided another letter in which Caldwell Memorial committed to financing a portion of the capital costs using funds on hand. *See Blue Ridge Healthcare Hosps. Inc. v. N. Carolina Dep't of Health & Human Servs.,* 255 N.C. App. 451, 463, 808 S.E.2d 271, 278–79 (2017). In short, the Court held that each of the co-applicants "separately documented the availability ***and*** commitment of funds." *Id.,* 255 N.C. App at 463, 808 S.E.2d at 279 (2017) (emphasis added).

Here, the required commitment from Adoration is simply missing. No letter from an authorized representative of Adoration commits to use funds obtained from BrightSpring (or even from the Phoenix Guarantor line of credit) to develop the proposed hospice agency or finance its associated working capital needs. An essential link in the chain of financing document is absent.

Mr. Fisher says he is responsible for financial operations and he is familiar with the financial position of various organizations on the applicant's organizational chart. He identifies dollar amounts for the estimated capital expenditure and working capital needs. He commits BrightSpring to provide cash ***to*** Adoration. He indicates BrightSpring can get cash using a line of credit. He commits Phoenix Guarantor ***to*** give Adoration money from the line of credit.

But … nowhere does Adoration ever commit to utilizing the cash provided by BrightSpring (or the credit line) to pay for the proposed capital costs or working capital needs of the proposed Adoration hospice agency in Rowan County.

This failure is fatal to a finding of conformity with Criterion 5 and renders the Adoration Application unapprovable as a matter of law.

Initial Operating Expenses

In reviewing Section F of the application, Initial Operating Period is defined as *"# of months from the time the facility begins offering the services proposed in this application until cash in-flow exceeds cash out-flow"*. For hospice offices, the initial operating period will include licensing, Medicare Certification, and ramping up both staffing and admissions. Adoration identified their Initial Operating Period as 5 months. According to ACHC who provides Accreditation Surveys for hospices, "*The organization must have provided care to a minimum of 5 patients (not required to be Medicare beneficiaries). At least 3 of the required 5 patients must be receiving care at the time of the Initial Medicare Certification Survey, unless in a medically underserved area as determined by the Regional Office*." A five-month time period seems an unrealistic amount of time to begin seeing patients, obtain Medicare Certification, and being able to financially sustain operations (especially considering the hospice office will not receive Medicare reimbursement during the certification period). The initial operating period expressed by Adoration is unreliable; thus, the amount of funding committed to the projects is unsubstantiated, resulting in the applicant's nonconformity to Criterion 5.

Form F.1a Errors

Section A.5. identifies Jessica Bailey-Wheaton as the Contact Individual and her title is CON Preparer. Her email is jbailey@healthcapital.com, which is a Consulting Firm located in St. Louis, Missouri. Healthcapital also provides consulting services for Certificates of Need. On form F.1.a. there are no expenses listed under Capital Costs for Consulting Services. As seen in other applications these costs range from $30,000 to $80,000 and would impact both Capitalization requirements as well as expenses related to Depreciation/Amortization. Adoration failed to include these applicable capital costs and expenses.

Form F.3 Errors

On page 106, Adoration states "PY1 reimbursement rates are based on Medicare Reimbursement Rates and Medicaid Reimbursement rates for the Charlotte-Concord-Gastonia Core Based Statistical Area." Adoration failed to account for the fact that Stanly County has a different reimbursement rate than Rowan County. The following table provides Medicare and Medicaid reimbursement rates for hospice services in Rowan County and Stanly County, respectively.

	FY2021 Hospice Wage Index Rates Rowan County	FY2021 Hospice Wage Index Rates Stanly County	FY2020 Medicaid Reimbursement Rates Rowan County	FY2020 Medicaid Reimbursement Rates Stanly County
Routine Home Care (per day) Days 1-60	$190.17	$171.87	$195.52	$176.39
Routine Home Care (per day) Days 61 and beyond	$150.32	$135.85	$154.53	$139.41
Continuous Home Care (per hour)	$56.96	$51.48	$58.40	$52.69
Respite Care (per day)	$444.54	$411.17	$480.30	$443.63
General Inpatient Care (per day)	$1,001.28	$911.79	$1,028.52	$935.04

Source: FY2020 Hospice Wage Index FINAL Rule published in Federal Register July 31, 2019; NC DHHS Division of Health Benefits 3.10.2020 Update

In response to Section C.2, Adoration projects Stanly County will comprise 45% of its hospice patient origin. Thus, failure to adjust Medicare and Medicaid reimbursement rates consistent with the projected patient origin results in unreliable revenues in Form F.4.

Further, Adoration assumes Medicare and Medicaid Routine Home Care payments based on the respective reimbursement rates for less than 60 days (weighted 50 percent) and the rate for 61 days or more (weighted 50 percent). However, Adoration does not project 50 percent of its days of care will exceed 60 days. Specifically, page 106 states "Adoration's Average Length of Stay is projected to be 57 days in PY 1, 62 days in PY 2, and 63 days in PY 3." Thus, there is no basis for Adoration to weight the reimbursement rate for 61 days or more by 50 percent. The impact of Adoration's weighing strategy results in lower projected revenues which could result in the Applicant "appearing" to be more competitive in a comparative analysis. However, any conclusion regarding Adoration's revenues in a comparative analysis would be based on erroneous projections because the reimbursement rates are not reasonable and adequately supported.

Adoration assumed no room and board charges (or expenses) stating "these charges and expenses are passed through at a revenue neutral rate." However, Adoration is incorrect on this assumption. See discussion regarding room and board under Form F.5.

Form F.4 Errors

In addition to unreliable revenues resulting from the Form F.3 errors previously described, Adoration failed to account for the time during its Medicare/Medicaid certification period in which it will not receive revenues from the respective payors. Based on CCNC's leadership experience developing new hospice offices, the certification period is approximately two months. Failure to account for two months of forgone revenue results in grossly overstated revenues during the first project year. As a result,

Adoration's projected initial operating expenses are grossly understated, which further emphasizes the previous deficiencies regarding failure to adequately demonstrate available capital for the project.

Adoration projects its charity care deduction to decrease in Project Year Two compared to Project Year 1 from $75,271 to $62,268. Curiously, the Applicant projects to reduce charity care projections from 7 patients in Project Year 1, to 5 patients in Project Year 2. The applicant provides not explanation why it intends to reduce charity care access during the second project year.

Form F.5 Errors

Nursing Home Room & Board

A Medicare-certified/NC Licensed hospice agency is able to provide hospice services in a nursing home facility where the recipient can be dually eligible for Medicaid where Medicaid covers the cost of the patients nursing home room and board less any patient share of cost. In North Carolina, the hospice agency must bill NC Medicaid for the room & board charges and in turn the hospice receives reimbursement at 95% and less any patient share of cost and Medicare pays the hospice for the hospice benefit. A hospice provider must have a contract with a nursing home if services are provided within those facilities which will include the guidance on how the nursing home room and board is handled including compensation.

In November 1997, the Office of the Inspector General reported on Hospice and Nursing Home Contractual Relationships and identified in their findings that "*Almost all hospices reviewed pay nursing homes the same or more than what Medicaid would have paid for nursing home care if the patient had not elected hospice.* " https://oig.hhs.gov/oei/reports/oei-05-95-00251.pdf With that being said, **there would be an expense created for the hospice of at least 5% which should be reported in the financials as a cost**. The basis for this cost would be the percentage of patients the hospices serve in nursing homes. NHPCO-Facts-Figures-2020-edition reported that at least 17.27% of patient's location of care is in a nursing facility. Similarly, based on the 2020 Hospice Data Supplements for the hospice offices located in Rowan County, approximately 19.9% of patients' care was provided in a nursing facility during FFY2019. Please see the following table.

Location of Care	Trellis Supportive Care (HOS2425)	Novant Health Hospice (HOS4599)	Combined Total	% of Total
Home	169	182	351	73.2%
Nursing Facility	74	53	127	19.9%
Hospice Unit		-	-	0.0%
Hospital		-	-	0.4%
Hospice IP Facility		-		-
Residential	34	17	51	6.6%
Total	277	252	529	100.0%

Source: 2020 Hospice Data Supplements, Section D, page 4

Therefore, based on the historical experience of hospice offices located in Rowan County, one can reasonably project that some percentage of patients will be served in a nursing facility. However, Adoration failed to identify any costs for Room & Board expense in Form F.5 Operating Costs.

For the aforementioned reasons, all applicants providing hospice services should include charges and expenses related to Nursing Home Room & Board passthrough. In reporting this expenditure for the CON, CCNC identified this expenditure as Room & Board Expense on Form F.5. Operating Costs. In addition, CCNC identified inpatient costs for respite and GIP stays at contracted facilities on the same form. Of the seven applicants in the Rowan Count hospice batch review, only two applicants (CCNC and Amedisys) identified that there was an expense related to servicing patients in a facility.

GIP & Respite Care

When GIP & Respite care is provided in a facility, a hospice must be contracted with a nursing facility, hospital or hospice inpatient facility in order to provide services to patients at those levels of care unless the agency operates their own hospice inpatient facility. Adoration does not indicate in Form F.5 Operating Costs or Assumptions that there is a charge for the contracted rates to facilities. In Project Year 3, HOIC indicates that there will be 108 Inpatient Care Days and 36 Respite Care Days ($133,311 total Revenue). Therefore, if Adoration projects to provide hospice days of care at both levels of care, Form F.5 Operating Costs should similarly reflect the facility costs to provide the services.

Adoration's projected operating costs are not reasonable and adequately supported because Form F.5 failed to include applicable Room & Board expense for hospice services provided in a nursing home, including costs for respite and GIP care. Consequently, Adoration does not conform to Criterion 5.

Criterion 7 "*The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided."*

Adoration's staffing is insufficient to provide staffing per its Average Caseload. Section H.2 requires the applicant to provide the average caseload by hospice discipline. In the hospice CON application, average caseload means the number of patients for which a staff member has responsibility or to which she or he is assigned at any one time. One can easily calculate the staff needed to support projected average caseload based on the following steps: 1) determine average daily census by dividing annual days of care by 365, 2) divide the average daily census by the average caseload for each staff discipline to determine the quotient, i.e. staff discipline needed.

The following table summarizes the staff required to meet Adoration's projected staffing needs for each staff discipline during the first three project years based on the Applicant's projected days of care (Form C) and the average case load per discipline (Section H.2).

		PY1	PY 2	PY 3
Form C Days of Care ÷ 365	Days of Care, PY2 ADC	7,569 20.7	11,644 31.9	16,473 45.1
H.2 ADC ÷ Avg Case Load Form H	RN Avg Case Load Staff Needed Staff Projected *RN Staff Surplus/(Deficit)*	12.0 1.73 1.70 *(0.03)*	12.0 2.66 2.70 *0.04*	12.0 3.76 3.80 *0.04*
H.2 ADC ÷ Avg Case Load Form H	SW Avg Case Load Staff Needed Staff Projected *SW Staff Surplus/(Deficit)*	31.0 0.67 0.60 *(0.07)*	31.0 1.03 1.00 *(0.03)*	31.0 1.46 1.40 *(0.06)*
H.2 ADC ÷ Avg Case Load Form H	Aide Avg Case Load Staff Needed Staff Projected *Aide Staff Surplus/(Deficit)*	13.0 1.60 1.60 *0.00*	13.0 2.45 2.50 *0.05*	13.0 3.47 3.50 *0.03*
H.2 ADC ÷ Avg Case Load Form H	Chaplain Avg Case Load Staff Needed Staff Projected *Chaplain Staff Surplus/(Deficit)*	51.0 0.41 0.40 *(0.01)*	51.0 0.63 0.60 *(0.03)*	51.0 0.88 0.90 *0.02*

As shown in the previous table, Adoration projects insufficient social worker and chaplain/clergy staff to support its projected average case load. The staffing needs are discipline specific; thus, the Applicant cannot claim the staffing deficits will met by an alternate staff discipline. The staffing deficiencies have multiple consequences to Adoration's application. Specifically,

- Adoration does not conform to Criterion 7 because it does not show evidence of adequate health manpower for the provision of the proposed hospice services.
- Adoration does not conform to Criterion 5 because its operating costs and resulting revenues are not based on adequate hospice staff projections.
- Adoration Average Case Load projections are not supported; therefore, the comparative analysis of this factor is inconclusive.

Criterion 8 *""The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system."*

In Section I.1 (page 64), Adoration identifies the ancillary and support services required for its proposal, which include:

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Respiratory Therapy
- Inpatient Care
- Respite Care
- Residential Care
- Pharmacy Services
- Durable Medical Equipment
- Medical Supplies

The Applicant refers to Exhibit I.1 for letters from some of Adoration's existing contracted service providers indicating their intent to extend their relationship to the proposed Rowan County hospice office, as well as an example of the Professional Services Agreement that the proposed facility would enter into with BrightSpring for the therapy services. However, Exhibit I.1 does not include a letter from the proposed provider of inpatient care, respite care, residential care, or medical supplies.

The Applicant also failed to identify whether dietary services will be available to the proposed Rowan County hospice office. Per 10A NCAC 13K .0102(6), "Dietary Counseling" means counseling given by a licensed dietitian as defined in G.S. 90-357. Adoration provided no documentation regarding availability of a dietician or how dietary counseling will be provided.

Consequently, the applicant does not adequately demonstrate that it will provide or make arrangements for the necessary ancillary and support services, and that the proposed services will be coordinated with the existing health care system. Therefore, the application is not conforming to this criterion.

Criterion 13c *"The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:*

> *(c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services."*

Adoration provides conflicting projections of charity care. For example, in response to Section C.6 (page 42), Adoration "commits to devoting at least 2.65% of its associated net revenue to charity care for indigent patients." Yet, in response to Section C.7 (page 45), Adoration projects 5% charity care in Project Year 1, with 2.65% charity care projected for Project Years 2 and 3. The information in the Application is contradictory and leaves uncertain whether Adoration intended to project 2.65% charity care in all three of its Project Years.

In regard to Access, the CON Application form asks applicants to (1) describe "how" each of several groups will have access to the services proposed; and (2) to provide "the estimated percentage" of new (unduplicated) in the third full fiscal year. Per N.C. Gen. Stat. § 131E-182, application forms must require such information as the Agency, by its rules deems necessary to conduct the review. An applicant is required to furnish only that information necessary to determine whether the proposed new institutional health service is consistent with the review criteria and with duly adopted standards, plans and criteria. In other words, the Agency can only ask for information it needs to conduct the review – when it fashions application questions, the Agency is defining what information it deems necessary. The information applicants are asked to provide is limited to information the Agency has determined to be *necessary* to show consistency with the review criteria. Yet, instead of answering these two specific requests for information deemed necessary by the Agency for the conduct of this review, Adoration provided a generalized discussion of its intentions for service to the identified groups without specifying "how" each group will have access and without providing the request "estimated percentage" of Year Three admissions for each group.

Criterion 18a *"The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact."*

Based on the facts which result in Bayada being non-conforming with Criteria 1, 3, 5, 6, 7, 8, and 13c, it should also be found non-conforming with Criterion 18a.

Comments Regarding Comparative Analysis

Service to Rowan County Residents

Applications in this batch were filed in response to the 2020 State Medical Facilities Plan Need Determination for one additional hospice home care agency in Rowan County. CCNC proposes that 95.9% of its new (unduplicated) admissions in its Third Full Fiscal Year will be admissions of patients residing in Rowan County, the county for which the SMFP showed a need. By contrast, Adoration proposes that only 57% of its new (unduplicated) admissions in the Third Full Fiscal Year will be admissions of patients residing in Rowan County.

In the 2018 Buncombe County Operating Room Review, Service to Residents of the Service Area was used as a Comparative Factor in the Agency's Comparative Analysis. In that Review, the Agency concluded that, generally, the application projecting to serve the highest percentage of Buncombe-Madison-Yancey multicounty OR planning area residents is the more effective alternative with regard to this comparative factor since the need determination is for two additional ORs to be located in this multi-county service area. The Agency determined that the applicant projecting to serve the highest percentage of Buncombe-Madison-Yancey multicounty OR planning area residents during the third operating year was the most effective alternative. Similarly, in the 2019 Wake County MRI Review, Service to Residents of the Service

Area was used as a Comparative Factor in the Agency's Comparative Analysis. In that Review, the Agency concluded that, generally, the application projecting to serve the highest percentage of Wake County MRI service area residents is the more effective alternative with regard to this comparative factor since the need determination is for one additional MRI to be located in the MRI service area. The Agency determined that the applicant projecting to serve the highest percentage of Wake County MRI service area residents during the third operating year was the most effective alternative.

As it did in the recent Buncombe OR Review and Wake County MRI Review, the Agency should conclude that the CCNC application is a more effective alternative than the Adoration application because CCNC projects to serve a higher percentage of Rowan County residents in the third operating year.

Access to a "New" Provider

The Agency evaluates access to a new provider in the context of the service at issue, here, hospice. That said, it is worth noting that Adoration is a subsidiary of Res-Care Holdings, Inc., which is a subsidiary of Res-Care, Inc. (doing business as BrightSpring Health Services, "BrightSpring") and, in March of this year, BrightSpring acquired the home health assets of *Advanced Home Care* (principally located in North Carolina). The acquisition included the Advanced Home Care home health agencies in various Counties, including Rowan County. While Adoration would be a new provider of hospice services in Rowan County, Adoration is a subsidiary of a company which now operates a home health agency in Rowan County, License No. HC0399. Presumably, there will be overlap in the Adoration policies, procedures and potentially overlap in the leadership/personnel involved in the Adoration operations in Rowan County.

By contrast, CCNC is new, not only to Rowan County, but to North Carolina. Patients and physicians will have the option to access a truly new alternative with CCNC.

Costs & Revenues

As previously described, Adoration's operating costs do not include applicable Room and Board expenses. See discussion regarding Criterion 5. Therefore, the conclusion of any comparative analysis of Adoration's costs and revenues would be inconclusive.

Medically Underserved Access

As compared to CCNC's application, Adoration's proposal is inferior with respect to medically underserved access. Adoration projects comparatively lower Medicaid access than CCNC. Adoration also projects a lower charity care deduction from revenue compared to CCNC.

Average Caseload for Key Staff Disciplines

As compared to CCNC's application, Adoration's proposal is inferior with respect to average caseload for key staff disciplines. Adoration projects comparatively higher average caseloads for RNs, social workers, hospice aides, and chaplains than CCNC.

COMMENTS SPECIFIC TO PRUITTHEALTH HOSPICE INC. (PruittHealth)
PROJECT ID No. F-011952-20

Criterion 1 *"The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which shall constitute a determinative limitation on the provision of any health services, health service facility, health service beds, dialysis stations, operating rooms, or home health offices that may be approved."*

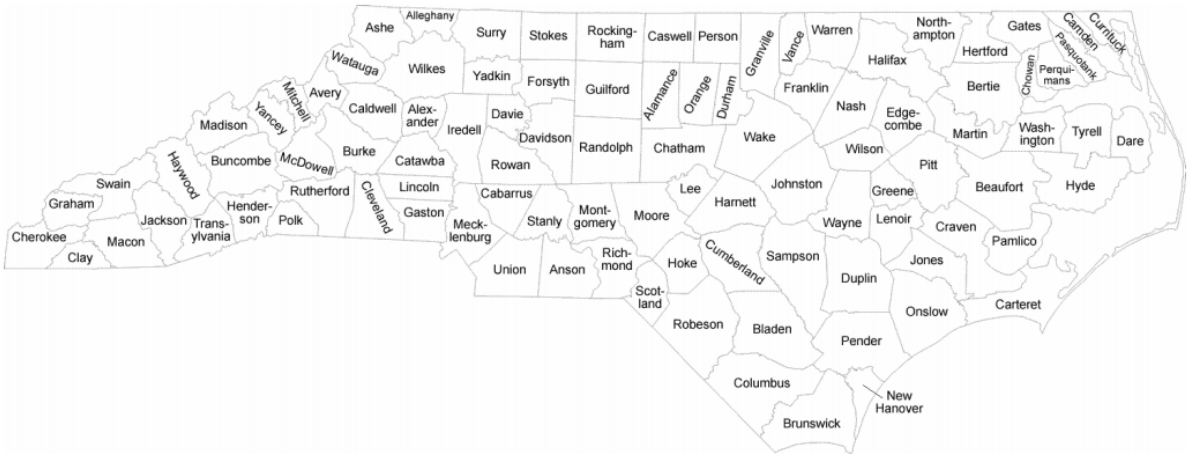
POLICY GEN-3: BASIC PRINCIPLES states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

PruittHealth fails to conform with Criterion 1 and Policy GEN-3 because the application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. The application does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. See discussion regarding criteria 3, 4, 5, 6, 8, 13c, and 18a. Therefore, the application is not conforming to this criterion and cannot be approved.

Criterion 3 *"The applicant shall identify the population to be served by the proposed project and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed."*

PruittHealth failed to identify the population to be served by the proposed project and adequately demonstrate the need the population has for the services proposed. Specifically, PruittHealth's patient origin projections are not reasonable and adequately supported. PruittHealth provides no reasonable explanation as to why it will serve a significant number of patients from Cabarrus, Mecklenburg, and Union to the south of Rowan County but not serve even a single patient in Iredell, Davie, or Davidson to the north of Rowan County (or Stanly County which is situated to the south with an SMPF deficit).



PruittHealth projects to serve patients residing in Forsyth and Guilford, but not one residing in Davidson or Randolph which both appear closer to Rowan County based on the above map. Based on the map, it would seem nurses and aides would likely drive through Davie, Davidson and/or Randolph Counties to reach patients' homes in Forsyth and Guilford counties. However, there is not a single patient projected to be served in any of those Counties in-between Rowan County and either Forsyth County or Guilford County.

Ultimately, the Project Analyst would have to guess as to why PruittHealth made such unusual patient origin projections – having to speculate in this fashion is the definitional opposite of having been provided reasonable assumptions.

The projected number of hospice patients to be served by the proposed PruittHealth Rowan County hospice home care office (see Section C.2, page 37) reflect a considerable burden to be imposed on hospice staff. For example,

- Pruitt states that over 11% of its admissions will be residents of Cabarrus County. The county seat of Cabarrus County is Concord which is over 20 miles and over 30 minutes from Salisbury.
- Pruitt states that over 11% of admissions will be residents of Guilford County. Greensboro is an hour's drive from Salisbury, over 50 miles, each way.
- Pruitt states that over 5% of its admissions will be residents of Mecklenburg County, home to Charlotte. Charlotte is over 40 miles and over 45 minutes from Salisbury.
- Pruitt states that fully 6.5% of its admissions will be residents of Union County, the county seat of which is Monroe. Monroe is over an hour from Salisbury, over 60 miles, each way.
- Pruitt states over 10% of its admissions will be residents of Forsyth County. Winston-Salem is over 40 miles/minutes from Salisbury.

The cities mentioned above are the population centers within the respective Counties; of course, there will be residents in these Counties whose homes may be closer or even more distant from Salisbury.

PruittHealth Hospice - Wilkes has provided hospice services to these counties from North Wilkesboro, a considerable distance from the homes of residents in the Counties noted above. While it may be possible to provide services across such long distances, doing so likely adds staff burden, travel time, expense, and inefficiency. Having staff who themselves reside in the community they serve is difficult to contemplate in the context of the Pruitt proposal to send staff out to places like Winston-Salem, Greensboro, and Charlotte with the hospice base of operations situated in Salisbury.

PruittHealth does not provide any meaningful discussion of operational issues and whether it is, or is not, optimal to endeavor to serve patients and families across such distances. However, on page 55, Pruitt claims there "are no alternative methods" to meet the needs for the proposed project because the existing hospice offices operated by PruittHealth *"*are **not close enough** to Rowan County to offer extensive hospice services*."* This seems counterintuitive given the distances PruittHealth Hospice – Wilkes staff are currently travelling to serve the same residents PruittHealth proposes to serve via the proposed Rowan County hospice home care office.

In Step 8 of its Need Methodology, Pruitt asserts, "PruittHealth Hospice's leadership believes that hospice patients from these [other] Counties can be **more efficiently served** from the PruittHealth Hospice – Salisbury location as compared to PruittHealth Hospice locations further away."

PruittHealth appears to assume the patient volume it served out of its North Wilkesboro hospice office will now be served out of the proposed Rowan County hospice home care office. For example,

- Per the 2020 SMFP, PruittHealth served 34 Guilford residents from its North Wilkesboro hospice office (HOS4413); PruittHealth projects to serve 35 Guilford residents from the proposed Rowan County hospice home care office per page 37 of its CON application.
- Per the 2020 SMFP, PruittHealth served 25 Cabarrus residents out of North Wilkesboro; PruittHealth projects to serve 35 Cabarrus residents from the proposed Rowan County hospice home care office per page 37 of its CON application.
- Per the 2020 SMFP, PruittHealth served 17 Mecklenburg residents out of North Wilkesboro; PruittHealth projects to serve 17 Mecklenburg residents from the proposed Rowan County hospice home care office per page 37 of its CON application.
- Per the 2020 SMFP, PruittHealth served 13 Union residents out of North Wilkesboro; PruittHealth projects to serve 20 Union residents from the proposed Rowan County hospice home care office per page 37 of its CON application.

By all appearances, Pruitt is just projecting to shift volume from its North Wilkesboro office to the proposed Rowan County hospice home care office, but that is an unsupported assumption as the referring physicians and communities would likely be quite different. And, considering physician and patient choice, it is unclear what support exists for just moving the hospice patient base as Pruitt appears to have done. Moreover, moving patients from one distant office to another distant office appears to accomplish little in terms of patient satisfaction, other than duplicating an already existing arrangement. But, if distance does matter, and an agency can provide more efficient service when it is closer to the homes of the patients and families it serves, why does PruittHealth project service to a considerable patient population living a significant distance outside Rowan County? If travel distances make providing "extensive" hospice services infeasible or sub-optimal, why then does PruittHealth propose to serve an

"extensive" percentage of patients (over 44%) from the Counties referenced above, all of which are at least thirty minutes, if not an hour or more, from Salisbury.

In summary, PruittHealth failed to demonstrate in its application that the hospice patients it proposes to serve need PruittHealth to locate an office in Rowan County as opposed to PruittHealth continuing to provide services to Rowan County residents from its Wilkes County hospice office (HOS4413). Further, PruittHealth did not demonstrate that the proposed hospice services would not duplicate the services provided by its Wilkes County hospice office given the number of hospice patients the applicant proposes to serve at the Rowan County hospice home care office.

Criterion 4 *"Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed."*

The PruittHealth application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. An application that cannot be approved cannot be an effective alternative.

The applicant does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. Therefore, the application is not conforming to this criterion and cannot be approved. See discussion regarding criteria 1, 3, 4, 5, 6, 18a.

Criterion 5 *"Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service."*

Initial Operating Expenses

In reviewing Section F of the application, Initial Operating Period is defined as *"# of months from the time the facility begins offering the services proposed in this application until cash in-flow exceeds cash out-flow"*. For hospice offices, the initial operating period will include licensing, Medicare Certification, and ramping up both staffing and admissions. PruittHealth identified their Initial Operating Period as 3 months. According to ACHC who provides Accreditation Surveys for hospices, "*The organization must have provided care to a minimum of 5 patients (not required to be Medicare beneficiaries). At least 3 of the required 5 patients must be receiving care at the time of the Initial Medicare Certification Survey, unless in a medically underserved area as determined by the Regional Office*." A three-month time period seems an unrealistic amount of time to begin seeing patients, obtain Medicare Certification, and being able to financially sustain operations (especially considering the hospice office will not receive Medicare reimbursement during the certification period). The initial operating period expressed by PruittHealth is unreliable; thus, the amount of funding committed to the projects is unsubstantiated, resulting in the applicant's nonconformity to Criterion 5.

Form F.3 Errors

As shown on Form F.3 PruittHealth assumes no reimbursement rate for Self-Pay.

PruittHealth failed to account for Medicare 2% sequestration adjustment.

Form F.4 Errors

PruittHealth assumes no reimbursement rate for Self-Pay; however, Form F. 4 includes Self-Pay revenue during each project year.

PruittHealth assumes no revenue for inpatient, respite, or continuous care for non-Medicare patients. Therefore, the Applicant does not propose comprehensive hospice access for Medicaid, charity care, self-pay, or commercial insurance patients.

PruittHealth failed to account for the time during its Medicare/Medicaid certification period in which it will not receive revenues from the respective payors. Based on CCNC's leadership experience developing new hospice offices, the certification period is approximately two months. Failure to account for two months of forgone revenue results in grossly overstated revenues during the first project year. As a result, PruittHealth's projected initial operating expenses are grossly understated, which results in failure to adequately demonstrate available capital for the project.

Form F.5 Errors

PruittHealth failed to account for workers compensation insurance.

PruittHealth failed to account for applicable Room & Board expenses in Form F.5 Operating Costs.

A Medicare-certified/NC Licensed hospice agency is able to provide hospice services in a nursing home facility where the recipient can be dually eligible for Medicaid where Medicaid covers the cost of the patients nursing home room and board less any patient share of cost. In North Carolina, the hospice agency must bill NC Medicaid for the room & board charges and in turn the hospice receives reimbursement at 95% and less any patient share of cost and Medicare pays the hospice for the hospice benefit. A hospice provider must have a contract with a nursing home if services are provided within those facilities which will include the guidance on how the nursing home room and board is handled including compensation.

In November 1997, the Office of the Inspector General reported on Hospice and Nursing Home Contractual Relationships and identified in their findings that "*Almost all hospices reviewed pay nursing homes the same or more than what Medicaid would have paid for nursing home care if the patient had not elected hospice.* " https://oig.hhs.gov/oei/reports/oei-05-95-00251.pdf With that being said, **there would be an expense created for the hospice of at least 5% which should be reported in the financials as a cost**. The basis for this cost would be the percentage of patients the hospices serve in nursing homes. NHPCO-Facts-Figures-2020-edition reported that at least 17.27% of patient's location of care is in a nursing facility. Similarly, based on the 2020 Hospice Data Supplements for the hospice offices located in Rowan County, approximately 19.9% of patients' care was provided in a nursing facility during FFY2019. Please see the following table.

Location of Care	Trellis Supportive Care (HOS2425)	Novant Health Hospice (HOS4599)	Combined Total	% of Total
Home	169	182	351	73.2%
Nursing Facility	74	53	127	19.9%
Hospice Unit		-	-	0.0%
Hospital		-	-	0.4%
Hospice IP Facility		-		-
Residential	34	17	51	6.6%
Total	277	252	529	100.0%

Source: 2020 Hospice Data Supplements, Section D, page 4

Therefore, based on the historical experience of hospice offices located in Rowan County, one can reasonably project that a comparable percentage of patients will be served in a nursing facility. However, PruittHealth failed to identify any costs for Room & Board expense in Form F.5 Operating Costs.

For the aforementioned reasons, all applicants providing hospice services should include charges and expenses related to Nursing Home Room & Board passthrough. In reporting this expenditure for the CON, CCNC identified this expenditure as Room & Board Expense on Form F.5. Operating Costs. In addition, CCNC identified inpatient costs for respite and GIP stays at contracted facilities on the same form. Of the seven applicants in the Rowan Count hospice batch review, only two applicants (CCNC and Amedisys) identified that there was an expense related to servicing patients in a facility.

Consequently, PruittHealth does not conform to Criterion 5 because it failed to account for Room and Board expenses associated with providing hospice care in a nursing home.

Form H Errors

PruittHealth does not project bereavement staff. Per 10A NCAC 13K .0501(8), “bereavement counseling shall be offered to family members and others identified in the bereavement plan of care for a period of 12 months after the patient patient's death.” Without a bereavement counselor, PruittHealth does not project adequate staff to support the services proposed.

Criterion 6 *“The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.”*

PruittHealth failed to adequately demonstrate the need for the proposed services (See Criterion 3). Therefore, PruittHealth failed to adequately demonstrate that its proposal will not result in an unnecessary duplication of existing or approved home health services and is nonconforming to this criterion.

Criterion 18a *“The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive*

impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact."

Based on the facts which result in PruittHealth being non-conforming with Criteria 1, 3, 4, 5, and 6, it should also be found non-conforming with Criterion 18a.

Criterion 20 "*An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past."*

PruittHealth is an applicant already involved in the provision of health services. As previously described, PruittHealth-Wilkes provides hospice services to Rowan County residents. PruittHealth also operates hospice offices in Craven, Cumberland, Edgecombe, and Pitt counties. PruittHealth also operates numerous nursing facilities in North Carolina and throughout the southeast.

PruittHealth-Carolina Point (Durham County) has been cited for multiple deficiencies during the last 18 months, including two fines totaling $14,927. On March 27, 2019, PruittHealth-Carolina Point was issued a $6,633 fine for failing to prevent a resident with dementia from exiting the facility while unsupervised for an unknown amount of time. The Resident was found outside lying in a drainage ditch approximately 178 feet away from the facility. The resident was returned inside the facility and his body temperature was below normal at 90.5 degrees Fahrenheit and he was transported to the hospital for evaluation. Also, on June 27, 2019, PruittHealth-Carolina Point was issued a $8,294 fine for failing to prevent staff to resident abuse.

On February 8, 2019, PruittHealth-Rockingham (Rockingham County) was fined $244,199 for failing to provide showers for residents.

On October 16, 2019, PruittHealth-Union Pointe was fined $9,360 for failure to provide incontinent care in a safe manner to prevent a fall from the bed with resulted in fractured leg.

The Georgia Department of Community Health (DCH) Healthcare Facility Regulation (HFR) division recently determined that a situation in which one of PruittHealth's facility's was noncompliant with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment or death to residents. PruittHealth-Palmyra's Administrator and Director of Health Services were informed of the Immediate Jeopardy on October 8, 2019 at 4:55 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on September 10, 2019. The U.S. Center for Medicare and Medicaid Services reports that it fined PruittHealth Palmyra $186,564.

The Agency should consider these quality deficiencies in its evaluation of PruittHealth's conformity to Criterion 20.

Comments Regarding Comparative Analysis

Costs & Revenues

As previously described, PruittHealth's operating costs and resulting revenues are not based on adequate hospice staff projections. See discussion regarding Criterion 5. Therefore, the conclusion of any comparative analysis of Carolina Caring's costs and revenues would be inconclusive.

Medically Underserved Access

As compared to CCNC's application, PruittHealth's proposal is inferior with respect to medically underserved access. PruittHealth projects comparatively lower charity care and Medicaid access than CCNC.

Patient Access to New Provider & Service to Residents of the Service Area

Regarding providing patients in Rowan County and surrounding areas with access to an alternative provider of hospice services, PruittHealth is not the most effective alternative because PruittHealth already serves Rowan County.

Pruitt states that it intends to serve Rowan, Guilford, Cabarrus, Mecklenburg, Union and Forsyth Counties. According to the Pruitt CON Application:

*"All these counties are **currently served** by PruittHealth Hospice – Wilkes…"*

Facilities may also serve residents of counties not included in their service area. The 2020 SMFP shows a deficit in hospice services in Stanly County. None of the other Counties bordering Rowan County shows a deficit in the 2020 SMPF. Yet, although it proposes to serve residents of several counties, without explanation, PruittHealth does not propose to serve any Stanly County residents.

The 2020 SMFP defines the service area for this Review as Rowan County. Generally, the application projecting to serve the highest percentage of Rowan County residents is the more effective alternative regarding this comparative factor since the need determination is for a hospice agency to be located in Rowan County. *See, e.g.,* 2018 OR Review for the multi-county service area including Buncombe County.

Applications in this batch were filed in response to the 2020 State Medical Facilities Plan Need Determination for one additional hospice home care agency in Rowan County. CCNC proposes that 95.9% of its new (unduplicated) admissions in its Third Full Fiscal Year will be admissions of patients residing in Rowan County, the county for which the SMFP showed a need. By contrast, PruittHealth proposes that less than 56% of its new (unduplicated) will be Rowan County residents (and 0% of its new (unduplicated) admissions will be Stanly County residents). PruittHealth is not the most effective alternative regarding service to residents of the service area.

In the 2018 Buncombe County Operating Room Review, Service to Residents of the Service Area was used as a Comparative Factor in the Agency's Comparative Analysis. In that Review, the Agency concluded that, generally, the application projecting to serve the highest percentage of Buncombe-Madison-Yancey multicounty OR planning area residents is the more effective alternative with regard to this comparative

factor since the need determination is for two additional ORs to be located in this multi-county service area. The Agency determined that the applicant projecting to serve the highest percentage of Buncombe-Madison-Yancey multicounty OR planning area residents during the third operating year was the most effective alternative. Similarly, in the 2019 Wake County MRI Review, Service to Residents of the Service Area was used as a Comparative Factor in the Agency's Comparative Analysis. In that Review, the Agency concluded that, generally, the application projecting to serve the highest percentage of Wake County MRI service area residents is the more effective alternative with regard to this comparative factor since the need determination is for one additional MRI to be located in the MRI service area. The Agency determined that the applicant projecting to serve the highest percentage of Wake County MRI service area residents during the third operating year was the most effective alternative.

As it did in the recent Buncombe OR Review and Wake County MRI Review, the Agency should conclude that the CCNC application is a more effective alternative than the PruittHealth application because CCNC projects to serve a higher percentage of Rowan County residents in the third operating year.

Average Case Load Per Staff Discipline

As compared to CCNC's application, PruittHealth's proposal is inferior with respect to average caseload for key staff disciplines. PruittHealth projects comparatively higher average caseloads for RNs, social workers, hospice aides, and chaplains than CCNC.

COMMENTS SPECIFIC TO CAROLINA CARING, INC. (Carolina Caring)
PROJECT ID No. F-011956-20

Criterion 1 *"The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which shall constitute a determinative limitation on the provision of any health services, health service facility, health service beds, dialysis stations, operating rooms, or home health offices that may be approved."*

POLICY GEN-3: BASIC PRINCIPLES states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

Per Criterion (1), a proposed project must be consistent with applicable policies in the State Medical Facilities Plan. Under Policy GEN-3: Basic Principles - applicable in this Review - an applicant must show how its proposed project will promote "equitable access" and must document how its projected volumes incorporate concepts of "equitable access" and address the needs of all residents in the proposed service area. Carolina Caring provided no description of how the underserved groups (i.e., low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, Medicare beneficiaries, and Medicaid recipients) would be expected to access services nor did it provide a single "estimated percentage" to identify the percentage of admissions in Year 3 which would be comprised of admissions of patients falling within each of the identified groups. Carolina Caring failed to provide requested information which, by definition, the Agency has determined necessary to conduct this Review. See additional discussion Criterion 3.

Carolina Caring fails to conform with Criterion 1 and Policy GEN-3 because the application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. The applicant does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. See discussion regarding criteria 3, 4, 5, 6, 7, 13c, and 18a. Therefore, the application is not conforming to this criterion and cannot be approved.

Criterion 3 "*The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women,*

handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed."

Section C.7 of the hospice CON Application form requires applicants to complete a table summarizing days of hospice care by location of service. Per N.C. Gen. Stat. § 131E-182, application forms must require such information as the Agency, by its rules deems *necessary* to conduct the review. An Applicant is required to furnish only that information necessary to determine whether the proposed new institutional health service is consistent with the review criteria and with duly adopted standards, plans and criteria. In other words, the Agency can only ask for information it needs to conduct the review – when it fashions application questions, the Agency is defining what information it deems necessary. The information applicants are asked to provide is limited to information the Agency has determined to be *necessary* to show consistency with the review criteria. Yet, instead of answering Section C.7, Carolina Caring stated the question is not applicable and referred to the hospice rules which were repealed in February 2019. Separate and apart from the expired rule, the Agency requests the applicant to project hospice care by location of service and by payor per Section C.7. This information is necessary assess the reasonableness of the Applicant's projections of revenue. See discussion regarding Criterion 5.

Need

In FFY2019, Carolina Caring's Catawba County hospice home care office (HOS0367) served 27 hospice patients in Rowan County which is 3.7% of the total number of Rowan County hospice patients served by all providers (27/738 = 0.0366). Carolina Caring failed to demonstrate in its application that the Rowan County residents it proposes to serve need Carolina Caring to locate an office in Rowan County as opposed to Carolina Caring continuing to provide services to Rowan County residents from its Catawba County hospice office (HOS0367). The Application included no information to explain why the Applicant's Catawba County hospice home care office is unable to serve the projected Rowan County hospice deaths. Further, Carolina Caring did not demonstrate that the proposed hospice services would not duplicate the services provided by its Catawba County hospice office given the number of Rowan County patients the applicant proposes to serve at the Rowan County hospice home care office.

Access

In regard to Access, Section C.6 of the hospice CON Application form asks applicants to (1) describe "how" each of several groups will have access to the services proposed; and (2) to provide "the estimated percentage" of new (unduplicated) admissions in the third full fiscal year.

Per N.C. Gen. Stat. § 131E-182, application forms must require such information as the Agency, by its rules deems *necessary* to conduct the review. An Applicant is required to furnish only that information necessary to determine whether the proposed new institutional health service is consistent with the review criteria and with duly adopted standards, plans and criteria. In other words, the Agency can only ask for information it needs to conduct the review – when it fashions application questions, the Agency is defining what information it deems necessary. The information applicants are asked to provide is limited to information the Agency has determined to be *necessary* to show consistency with the review criteria. Yet, instead of answering Section C.6's two specific requests for information deemed necessary by the Agency for the conduct of this review, Carolina Caring provided a short reference to its non-discrimination policies and stated a "significant proportion" of its services would be provided to "Medicare, Medicaid,

and uninsured patients." Carolina Caring provided no description of how the listed groups would be expected to access services nor did it provide a single "estimated percentage" to identify the percentage of admissions in Year 3 which would be comprised of admissions of patients falling within each of the identified groups. Carolina Caring failed to provide requested information which, by definition, the Agency has determined necessary to conduct this Review. The information has obvious relevance and importance to an appropriate assessment of "Access" under several of the key statutory Review Criteria.

Per Criterion 3, the applicant must identify "the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed." This is the information sought by Question 6 in Section C. Without the necessary information sought by this question, an applicant cannot fairly be found conforming to Criterion 3.

Further, on page 113, Carolina Caring states it "recognizes the need for increased awareness and increased education regarding hospice services, including by veterans, African Americans and minority populations." However, a review of Carolina Caring's historical utilization indicates a lack of access for minority populations. Section G of Carolina Caring's 2020 Hospice Data Supplement provides patient demographics for new (unduplicated) hospice admissions. During FFY2019, only 7.4% of hospice admissions (which includes Rowan County patients) were African American. The vast majority of Carolina Caring's FFY2019 hospice admissions were white (1,224 ÷ 1,363). In addition to failing to address the estimated percentage of minorities that will have access to the proposed hospice services, Carolina Caring failed to reconcile its own historical experience and lack of minority access with the need for minority access in Rowan County.

Criterion 4 *"Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed."*

The Carolina Caring application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. An application that cannot be approved cannot be an effective alternative.

The applicant does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. Therefore, the application is not conforming to this criterion and cannot be approved. See discussion regarding criteria 1, 3, 5, 6, 7, 18a.

Criterion 5 *"Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service."*

Carolina Caring does not conform to Criterion 5 because its operating costs and resulting revenues are not based on adequate hospice staff projections. See discussion regarding Criterion 8.

The Carolina Caring application also contained the following errors and omissions.

Initial Operating Expenses

In Section F of the application, Initial Operating Period is defined as *"# of months from the time the facility begins offering the services proposed in this application until cash in-flow exceeds cash out-flow"*. For hospice offices, the initial operating period will include licensing, Medicare Certification, and ramping up both staffing and admissions. Carolina Caring identified their Initial Operating Period as 3 months. According to ACHC who provides Accreditation Surveys for hospices, "*The organization must have provided care to a minimum of 5 patients (not required to be Medicare beneficiaries). At least 3 of the required 5 patients must be receiving care at the time of the Initial Medicare Certification Survey, unless in a medically underserved area as determined by the Regional Office*." A three-month time period seems an unrealistic amount of time to begin seeing patients, obtaining Medicare Certification, and being able to financially sustain operations (especially considering the hospice office will not receive Medicare reimbursement during the certification period). The initial operating period expressed by Carolina Caring is unreliable; thus, the amount of funding committed to the projects is unsubstantiated, resulting in the applicant's nonconformity to Criterion 5.

Form F.4 Errors

As described in the discussion of Criterion 3, Carolina Caring failed to respond to Section C.7 and provide projected days of care by location of service and by payor. This information is necessary to determine whether the total combined number of days to hospice care furnished to Medicaid and Medicare patients provided outside the patient's residence exceeds the 20 percent limitation described in 42 CFR 418.302(f)(2). Per 42 CFR 418.302(f)(2), at the end of a cap period, the Medicare Administrative Contractor calculates a limitation on payment for inpatient care to ensure that Medicare payment is not made for days of inpatient care in excess of 20 percent of the total number of days of hospice care furnished to Medicare patients. Absent any information in response to Section C.7, it is not known whether Carolina Caring projects to exceed the 20 percent limitation. Therefore, Carolina Caring's Form F.5 revenue projections are unreliable.

Also, Carolina Caring failed to properly project revenue for continuous home care (CHC) hospice services. CHC is one of the four levels of hospice care in the Medicare Hospice Benefit and required by the Medicare hospice regulations. To qualify and bill for CHC billing, the hospice must provide a **minimum of eight (8) hours** of care during a 24-hour period. However, Carolina Caring inappropriately projects to receive CHC revenue for less than the minimum 8 hours of care. For example, Form F.3 projects CHC Medicaid reimbursement at $58.98 in Project Year 2. In Form F.4, Carolina Caring projects to CHC Medicaid gross revenue at $402. The projected Project Year 2 CHC revenue reflects only 6.8 hours of continuous home care ($402 ÷ $58.98 = 6.8), which is less than the minimum 8 hours of care. The following table summarizes Carolina Caring's errors in CHC billing during first three project years for each payor source (increments of <8 hours are reflected in red). Also, the total CHC hours billed based on the Applicant's F.4 revenues does not reconcile with the total continuous care hours projected in Form C.

Form F.3 Reimbursement Rate

	PY1	PY2	PY3
Self-Pay/ Charity Care	$0.00	$0.00	$0.00
Medicare	$56.96	$57.53	$58.11
Medicaid	$58.40	$58.98	$59.57
Insurance	$9.99	$10.09	$10.20
Other	$6.31	$6.37	$6.44

Form F.4 Revenue

	PY1	PY2	PY3
Self-Pay/ Charity Care	$21	$38	$64
Medicare	$3,751	$7,440	$12,524
Medicaid	$184	$402	$677
Insurance	$61	$110	$186
Other	$1	$3	$4

Continuous Care Hours Billed

	PY1	PY2	PY3
Self-Pay/ Charity Care	--	--	--
Medicare	65.9	129.3	215.5
Medicaid	3.2	6.8	11.4
Insurance	6.1	10.9	18.2
Other	0.2	0.5	0.6
Total Hours	75.3	147.5	245.7

Also, Carolina Caring projects no SIA revenue. Therefore, a comparison of projected average net revenue per patient and per unduplicated admission between Carolina Caring and CCNC would not be an "apples to apples" comparison. As described previously, CCNC's projected net revenue includes SIA payments which are separately itemized from its Medicare revenue by level of care. Therefore, CCNC's projected average net revenue per patient day and per patient are reflective of its commitment to provision of high quality, service-intense hospice services. Carolina Caring's average net revenue per patient day and per patient may be comparatively lower due to the omission of SIA payments. By not including a revenue estimate for the SIA payment, and providing staffing levels that purport a high visit frequency, Carolina Caring is inaccurately reporting their revenue.

Form F.5 Errors

Carolina Caring failed to include amortization of their applicable Capital Costs and Startup Costs. Carolina Caring only shows "equipment depreciation" of $10K. Per the IRS, business start-up and organizational costs are generally capital expenditures. Businesses can elect to deduct up to $5,000 of business start-up and $5,000 of organizational costs paid or incurred after October 22, 2004. The $5,000 deduction is reduced by the amount the business' total start-up or organizational costs exceed $50,000. Any remaining costs must be amortized. In Section F, Carolina Caring projects $40,000 in startup expenses. These expenses are not depreciated in Form F.5. In Form F.1a, Carolina Caring projects $45,000 in consulting fees, which are not amortized in Form F.5.

Form F.5 includes no expenses related to software or technology with the exception of mobile phones. Hospices must purchase and license software for staff to document care. Hospice software licensing fees are separate from hardware expenses. Carolina Caring failed to account for any hospice licensing fees.

Nursing Home Room & Board

A Medicare-certified/NC Licensed hospice agency is able to provide hospice services in a nursing home facility where the recipient can be dually eligible for Medicaid where Medicaid covers the cost of the patients nursing home room and board less any patient share of cost. In North Carolina, the hospice agency must bill NC Medicaid for the room & board charges and in turn the hospice receives reimbursement at 95% and less any patient share of cost and Medicare pays the hospice for the hospice benefit. A hospice provider must have a contract with a nursing home if services are provided within those facilities which will include the guidance on how the nursing home room and board is handled including compensation.

In November 1997, the Office of the Inspector General reported on Hospice and Nursing Home Contractual Relationships and identified in their findings that "*Almost all hospices reviewed pay nursing homes the same or more than what Medicaid would have paid for nursing home care if the patient had not elected hospice.* " https://oig.hhs.gov/oei/reports/oei-05-95-00251.pdf With that being said, **there would be an expense created for the hospice of at least 5% which should be reported in the financials as a cost**. The basis for this cost would be the percentage of patients the hospices serve in nursing homes. NHPCO-Facts-Figures-2020-edition reported that at least 17.27% of patient's location of care is in a nursing facility. Indeed, Carolina Caring's 2020 Hospice Data Supplement indicates 15.11% of its patients' location of care was provided in a nursing facility during FFY2019 (see Section D, page 4 of Carolina Caring's 2020 Hospice Data Supplement HOS0367; 206 ÷ 1,363 = .1511). Similarly, based on the 2020 Hospice Data Supplements for the hospice offices located in Rowan County, approximately 19.9% of patients' care was provided in a nursing facility during FFY2019. Please see the following table.

Location of Care	Trellis Supportive Care (HOS2425)	Novant Health Hospice (HOS4599)	Combined Total	% of Total
Home	169	182	351	73.2%
Nursing Facility	74	53	127	19.9%
Hospice Unit		-	-	0.0%
Hospital		-	-	0.4%
Hospice IP Facility		-		-
Residential	34	17	51	6.6%
Total	277	252	529	100.0%

Source: 2020 Hospice Data Supplements, Section D, page 4

Therefore, based on Carolina Caring's own experience and the historical experience of hospice offices located in Rowan County, one can reasonably project that some percentage of patients will be served in a nursing facility. However, Carolina Caring failed to identify any costs for Room & Board expense in Form F.5 Operating Costs.

For the aforementioned reasons, all applicants providing hospice services should include charges and expenses related to Nursing Home Room & Board passthrough. In reporting this expenditure for the CON, CCNC identified this expenditure as Room & Board Expense on Form F.5. Operating Costs. In addition, CCNC identified inpatient costs for respite and GIP stays at contracted facilities on the same form. Of the seven applicants in the Rowan Count hospice batch review, only two applicants (CCNC and Amedisys) identified that there was an expense related to servicing patients in a facility.

Carolina Caring's projected operating costs are not reasonable and adequately supported because Form F.5 failed to include:

- Adequate staffing costs to cover projected average caseload per staff discipline, and
- Room & Board expense for hospice services provided in a nursing home

Consequently, Carolina Caring does not conform to Criterion 5.

Criterion 6 "The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities."

Carolina Caring did not demonstrate that the proposed hospice services would not duplicate the services provided by its Catawba County hospice office. See discussion regarding Criterion 3.

Criterion 7 "*The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided."*

Carolina Caring's staffing is insufficient to provide staffing per its Average Caseload. Section H.2 requires the applicant to provide the average caseload by hospice discipline. In the hospice CON application, average caseload means the number of patients for which a staff member has responsibility or to which she or he is assigned at any one time. One can easily calculate the staff needed to support projected average caseload based on the following steps: 1) determine average daily census by dividing annual days of care by 365, 2) divide the average daily census by the average caseload for each staff discipline to determine the quotient, i.e. staff discipline needed.

The following table summarizes the staff required to meet Carolina Caring's projected staffing needs for each staff discipline during the first three project years based on the Applicant's projected days of care (Form C) and the average case load per discipline (Section H.2).

		PY1	PY 2	PY 3
Form C Days of Care ÷ 365	Days of Care, PY2 ADC	10,009 27.4	12,969 35.5	16,092 44.1
H.2 ADC ÷ Avg Case Load Form H	RN Avg Case Load Staff Needed Staff Projected *RN Staff Surplus/(Deficit)*	12.0 2.29 2.25 *-0.04*	12.0 2.96 3.50 *0.54*	12.0 3.67 4.00 *0.33*
H.2 ADC ÷ Avg Case Load Form H	SW Avg Case Load Staff Needed Staff Projected *SW Staff Surplus/(Deficit)*	35.0 0.78 0.75 *(0.03)*	35.0 1.02 1.00 *(0.02)*	35.0 1.26 1.25 *(0.01)*
H.2 ADC ÷ Avg Case Load Form H	Aide Avg Case Load Staff Needed Staff Projected *Aide Staff Surplus/(Deficit)*	10.0 2.74 2.00 *(0.74)*	10.0 3.55 3.00 *(0.55)*	10.0 4.41 4.00 *(0.41)*
H.2 ADC ÷ Avg Case Load Form H	Chaplain Avg Case Load Staff Needed Staff Projected *Chaplain Staff Surplus/(Deficit)*	50.0 0.55 0.50 *(0.05)*	50.0 0.71 0.50 *(0.21)*	50.0 0.88 0.60 *(0.28)*

As shown in the previous table, Carolina Caring projects insufficient social worker, hospice aide, and chaplain/clergy staff to support its projected average case load. The staffing needs are discipline specific; thus, the Applicant cannot claim the staffing deficits will met by an alternate staff discipline. The staffing deficiencies have multiple consequences to Carolina Caring's application. Specifically,

- Carolina Caring does not conform to Criterion 7 because it does not show evidence of adequate health manpower for the provision of the proposed hospice services.
- Carolina Caring does not conform to Criterion 5 because its operating costs and resulting revenues are not based on adequate hospice staff projections.
- Carolina Caring's Average Case Load projections are not supported; therefore, the comparative analysis of this factor is inconclusive.

Criterion 13 *"The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:*

(a) The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

(b) Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

(c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

(d) That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians."

Per Criterion 13, an applicant must demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. To demonstrate conformity with subpart (c) of Criterion (13), the applicant must show that the elderly

and medically underserved groups will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services.

As described previously, Carolina Caring provided no description of how the listed groups (i.e., low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, Medicare beneficiaries, and Medicaid recipients) would be expected to access services nor did it provide a single "estimated percentage" to identify the percentage of admissions in Year 3 which would be comprised of admissions of patients falling within each of the identified groups. Indeed, Carolina Caring's historical experience indicates a lack of access for minority populations (see discussion regarding Criterion 3).

Per subsection (d) of Criterion (13), the applicant must show "means" of access such as access via physician referrals. This is the information sought by Question 6 in Section C. Without the necessary information sought by this question (see discussion regarding Criterion 3), an applicant cannot fairly be found conforming to Criterion (13)(c) or (d).

Criterion 18a *"The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact."*

Per Criterion (18a), an applicant must demonstrate how any enhanced competition will have a positive impact on access to the services proposed. The information sought by Question 6 in Section C is necessary to assess how each proposed project will impact "access" to the services proposed (see discussion regarding Criterion 3). Without the necessary information sought by this question, an applicant cannot fairly be found conforming to Criterion (18a).

Also, based on the facts which result in Carolina Caring being non-conforming with Criteria 1, 3, 5, 6, 7, 8, and 13, it should also be found non-conforming with Criterion 18a.

Comments Regarding Comparative Analysis

Costs & Revenues

As previously described, Carolina Caring's operating costs and resulting revenues are not based on adequate hospice staff projections. See discussion regarding Criterion 7. Therefore, the conclusion of any comparative analysis of Carolina Caring's costs and revenues would be inconclusive.

Medically Underserved Access

As compared to CCNC's application, Carolina Caring's proposal is inferior with respect to medically underserved access. Carolina Caring projects comparatively lower charity care and Medicaid access than CCNC.

Access to a "New" Provider/Competition

Carolina Caring's proposal is the least effective alternative with respect to access to a new provider. Carolina Caring provides hospice services to Rowan County patients via its Catawba County hospice office (HOS0367). Carolina Caring will not facilitate access to a new hospice provider for Rowan County hospice patients.

Average Case Load Per Staff Discipline

As previously described, Carolina Caring's Average Case Load projections are not supported; therefore, the comparative analysis of this factor is inconclusive.

COMMENTS SPECIFIC TO PERSONAL HOME CARE OF NORTH CAROLINA (PHC)
PROJECT ID No. F-011957-20

Criterion 1 *"The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which shall constitute a determinative limitation on the provision of any health services, health service facility, health service beds, dialysis stations, operating rooms, or home health offices that may be approved."*

POLICY GEN-3: BASIC PRINCIPLES states:

"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

PHC fails to conform with Criterion 1 and Policy GEN-3 because the application is not conforming to all other applicable statutory and regulatory review criteria and thus, is not approvable. The applicant does not adequately demonstrate that the proposal is its least costly or most effective alternative to meet the need. See discussion regarding criteria 3, 4, 5, 6, 7, 8, 13c, and 18a. Therefore, the application is not conforming to this criterion and cannot be approved.

Criterion 4 "*Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed."*

PHC is nonconforming with the following statutory review criteria: Criteria 1, 5, 6, and 18a. See these criteria for discussion. Therefore, PHC failed to adequately demonstrate that its proposal is an effective alternative for development of a hospice home care office in Rowan County. Consequently, the application is nonconforming to this criterion.

Criterion 5 *"Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service."*

<u>Form F.5 Errors</u>

The PHC application failed to account for applicable Room & Board expenses in Form F.5 Operating Costs.

A Medicare-certified/NC Licensed hospice agency is able to provide hospice services in a nursing home facility where the recipient can be dually eligible for Medicaid where Medicaid covers the cost of the patients nursing home room and board less any patient share of cost. In North Carolina, the hospice agency must bill NC Medicaid for the room & board charges and in turn the hospice receives reimbursement at 95% and less any patient share of cost and Medicare pays the hospice for the hospice benefit. A hospice provider must have a contract with a nursing home if services are provided within those facilities which will include the guidance on how the nursing home room and board is handled including compensation.

In November 1997, the Office of the Inspector General reported on Hospice and Nursing Home Contractual Relationships and identified in their findings that "*Almost all hospices reviewed pay nursing homes the same or more than what Medicaid would have paid for nursing home care if the patient had not elected hospice.* " https://oig.hhs.gov/oei/reports/oei-05-95-00251.pdf With that being said, **there would be an expense created for the hospice of at least 5% which should be reported in the financials as a cost**. The basis for this cost would be the percentage of patients the hospices serve in nursing homes. NHPCO-Facts-Figures-2020-edition reported that at least 17.27% of patient's location of care is in a nursing facility. Similarly, based on the 2020 Hospice Data Supplements for the hospice offices located in Rowan County, approximately 19.9% of patients' care was provided in a nursing facility during FFY2019. Please see the following table.

Location of Care	Trellis Supportive Care (HOS2425)	Novant Health Hospice (HOS4599)	Combined Total	% of Total
Home	169	182	351	73.2%
Nursing Facility	74	53	127	19.9%
Hospice Unit		-	-	0.0%
Hospital		-	-	0.4%
Hospice IP Facility		-		-
Residential	34	17	51	6.6%
Total	277	252	529	100.0%

Source: 2020 Hospice Data Supplements, Section D, page 4)

Therefore, based on the historical experience of hospice offices located in Rowan County, one can reasonably project that a comparable percentage of patients will be served in a nursing facility. However, PHC failed to identify any costs for Room & Board expense in Form F.5 Operating Costs.

For the aforementioned reasons, all applicants providing hospice services should include charges and expenses related to Nursing Home Room & Board passthrough. In reporting this expenditure for the CON, CCNC identified this expenditure as Room & Board Expense on Form F.5. Operating Costs. In addition, CCNC identified inpatient costs for respite and GIP stays at contracted facilities on the same form. Of the seven applicants in the Rowan Count hospice batch review, only two applicants (CCNC and Amedisys) identified that there was an expense related to servicing patients in a facility.

Consequently, PHC does not conform to Criterion 5 because it failed to account for Room and Board expenses associated with providing hospice care in a nursing home.

Criterion 18a *"The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact."*

Based on the facts which result in PHC being non-conforming with Criteria 1, 4, and 5, it should also be found non-conforming with Criterion 18a.

Comments Regarding Comparative Analysis

Costs & Revenues

As previously described, PHC operating costs and resulting revenues are not based on adequate hospice staff projections. See discussion regarding Criterion 5. Therefore, the conclusion of any comparative analysis of PHC's costs and revenues would be inconclusive.

Medically Underserved Access

As compared to CCNC's application, PHC's proposal is inferior with respect to medically underserved access. PHC projects comparatively lower charity care and Medicaid access than CCNC.

Average Case Load Per Staff Discipline

As compared to CCNC's application, PHC's proposal is inferior with respect to average caseload for key staff disciplines. PHC projects comparatively higher average caseloads for RNs, social workers, hospice aides, and chaplains than CCNC.